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The following U.S. patents may apply to portions of the MPDS or software depicted in this periodical: 5,857,966; 6,010,451; 6,053,864; 6,076,065; 6,078,894; 6,106,459; 6,607,481; 7,106,835; 7,428,301; 7,645,234; 8,066,638; 8,103,523; 8,294,570; 8,335,298; 8,488,748; 8,494,868; 8,572,020; 8,873,719. The PPDS is protected by U.S. patent 8,417,533. Other U.S. and foreign patents pending.

Protocol-related terminology in this text is additionally copyrighted within each of the IAED’s discipline-specific protocols. Original MPDS, FPDS, and PPDS copyrights established in September 1979, August 2000, and August 2001, respectively. Subsequent editions and supporting material copyrighted as issued. Portions of this periodical come from material previously copyrighted beginning in 1979 through the present.

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Art is a software instructor and IAED™-certified EMD-Q® instructor for Priority Dispatch Corp.™ He has been a fire and EMS dispatcher for 20 years and is a former air medical dispatcher. He currently works at Union County Regional Communications in Westfield, New Jersey (USA).

Art Braunschweiger
9 | From The EMD Side

Andre is Assistant Executive Director of Communications and Control Centers for Hamad Medical Corporation, the national ambulance service in the State of Qatar in the Middle East. He is a Master Software Instructor and National Q Evaluator for Priority Dispatch Corp. as well as an Adjunct Instructor at Jacksonville State University’s Department of Emergency Management where he earned his BSc, M.S., and M.P.A. He is currently working on a Ph.D.

Andre V. Jones
10 | Guest Writer

Sherri is the training and operations manager for Waukesha County Communications, Wisconsin (USA), a combined dispatch center in southeastern Wisconsin, just west of Milwaukee, a land where the beer runs freely and locals proudly stack cheese on just about everything and call it great. You can contact Sherri at 262-446-5085 or by email at sstigler@waukeshacounty.gov.

Sherri Stigler
11 | Lean In

Holli began her dispatching career in 1989 with the Naples (Florida, USA) Police Department. In December 1990, she started with Lee County 9-1-1 Emergency Dispatch Center and became Lieutenant in 2004. Holli loves the career she has chosen. Retiring will be the hardest thing for her to do.

Holli Jordan
14 | Ace Achievers

Talley has been a Public Safety Telecommunicator with the Richardson Police Department (Texas, USA) for almost three years, dispatching police, fire and EMS. She will soon begin training to become a communications training officer. Talley has a bachelor’s degree in Spanish from the University of Houston.

Talley Johnson
16 | Center Piece
I’ve never read anything like it. In all the years I’ve sat down at my cubicle desk, turned on the computer, greeted co-workers (well, at least try to remember to do that), and dived into the daily flow of things it would be good to get done, I’ve never read such a fabulous collection of stories and columns in one issue. Truly. What makes this issue so great? Our members.

In this issue of the Journal, we announce the winners of the first-ever Center Piece contest. Journal staff did not write these stories. We did not conduct the interviews or decide what to put in or leave out of a story. We asked members to send us “the scoop” about their center. Period. The interpretation of the minimal directive is amazing. We learned about center history, the area each dispatch center covers, and about the people—the first, first responders—who come in at the start and influence the situations unfolding by the second.

We had a tough time deciding on the top two stories (ACE and not an ACE) and finally, after much back-and-forth, chose an additional three runners up; they will be published in the November/December issue. We encourage everyone to read the stories AND make it your goal to write a piece about your center (contest or not). Let your great work be read around the world.

We also take a look at rural centers, which Communication Manager Josh McFadden found (for purposes of the article) as unique in the size of the area covered as they are in familiarity with their callers and terrain. Just ask Dana Bell, public safety communications manager with Taber Police Service in Taber, Alberta (Canada), what it takes in an area where addresses are seldom posted. “If you aren’t familiar with the area, it’s near impossible to dispatch to a location at times.”

You can read about the Medical Priority Dispatch System® (MPDS®) Breathing Verification Tool available in version 13.1. A columnist new to the Journal, Andre V. Jones, explains the impact of a leader’s attitude in a crisis, and Journal Senior Copy Editor Heather Darata describes the value of personality tests to build and nurture a complementary work team. The “add this to your ‘to-do’ list” reminder comes from Journal Writer Becca Barrus, who cautions against preparedness procrastination (floods, fault lines, and power outages, oh my).

A final thought: We like hearing from our members. We like to hear about your calls and the places where you work. So if you have a moment, drop us a line at editor@emergencydispatch.org and help make the next Journal every bit as good as this one.
get more than a little excited discovering things about myself. There are quite a few ways to know more about what makes you tick. One of my favorite ways is to take fun tests that offer insight that you might not get any other way.

What’s best is taking the kind of tests that offer positive feedback. One I recently discovered (thanks to Kim Rigden, IAED™ Associate Director of Accreditation) identified how 24 strengths rank for me. The VIA Institute on Character survey is available to anyone (viacharacter.org/www/Character-Strengths-Survey). I like how it doesn’t label things as weaknesses.

The order of your strengths helps you know where you excel and where you might be underusing a strength. Also, just because you rank highly in a strength doesn’t mean that there isn’t any room for change there because you might be overusing a strength.

The VIA Classification of 24 Character Strengths breaks the strengths into six categories: Wisdom, Courage, Humanity, Justice, Temperance, and Transcendence. My top 5 strengths spanned four of the six categories. Even more interesting, my bottom 5 strengths are from only three of the six categories.

I have no doubt why I scored high numbers in my top 5 character strengths: Spirituality, Judgment, Love, Prudence, and Gratitude. Faith plays a huge role in my life. I see how I use critical thinking and don’t jump to conclusions when I make decisions. I absolutely value my relationships with my husband, family, and friends. I am definitely careful in what I say and do. I do believe that I have a lot to be grateful for in my life.

In the IAED Academics, Research, and Communications Department, we all took the VIA Character Strengths test and compiled our top 5 and bottom 5 strengths. I have used this information about those I work with in order to understand them better. It has already helped me in my interactions with co-workers. For example, I realized that most of my co-workers and I didn’t have self-regulation (at least when it comes to food!) in our top 5. Now I’m not surprised to see how quickly the candy bowl is empty. Other co-workers didn’t have social intelligence rank high on their list. I started to realize that they might view our interactions differently than I do. A few found bravery near the bottom of their list (like me), which helped me realize that they might not enjoy standing up for their opinions and ideas.

It was also fascinating to see how alike some of my co-workers were in their top 5 strengths. But I can also see how different we are. Our differences help us with our different roles and tasks while our similarities help us work well together as a group.
Brett,

I think the training point for the EMD is to ensure that they are selecting HIGH VELOCITY off of Sub-CC. If the EMD selects Protocol 29: Traffic/Transportation Incidents without a sub they would see the option under the first KQ, but when selecting Vehicle vs. Vehicle off sub they will miss that as a more specific option should it be appropriate.

Do we have any documentation on Sub-Chief Complaint prioritization? I am wondering if that would assist our emergency dispatchers for these types of selections?

Thank You,
Tony Guido, Program Administrator
Fire/Medical/Quality
Priority Dispatch Corp.”

Hi Tony:
The Sub-CC field is new, and EMDs are just getting used to it. Doc and the gang are working on some problem areas where uncommon complaints are coming up first and being selected accidentally, so there will be some tweaking in software land. Overall the reviews have been good, and I think EMDs will appreciate the efficiency of this new feature once they get accustomed to it.

I am not aware of any specific training document, and I’m not sure it warrants one. But perhaps an article for the Journal would be helpful. Any volunteers?

Brett A. Patterson
Academics & Standards Associate Chair, Medical Council of Standards IAED™

All,

I began working on an article over the last few weeks that is geared more toward the Q side outlining Final Code Validation and leveraging these concepts for “Chief & Sub-Chief Complaint” validation. I LOVE the new Final Code Validation, and it falls right in line with ensuring protocol accuracy as well. As I have walked around many centers it is not uncommon to see an EMD, EPD, or EFD fly through the Case Entry Questions and swiftly, if sometimes violently, select a protocol. With the Sub-Chief Complaints, that momentary pause to validate your selection should be a celebrated practice.

I know there has been some discussion on pulling back from the more infrequent subs in medical such as “head out” or “sickle cell.” I would want the article to fall in line with the most current direction so it may need to follow an updated release.

Thoughts?
Tony

Tony,

Thanks for the follow-up on this thing. Just before the last release, we removed the Sickle Cell Crisis and Thalassemia choices from the P-26 Sub-CC list. These should be out there now—for those that updated. They were very rare and actually are not Sub-CCs but diagnoses—although, if they were very common, we would have left them in. We didn’t change the “head” issue, as the “head visible” and “head out” are critical things that need quickest path—interestingly, this is only a problem on female cases. On those, the EMD will just have to learn that Headache requires typing in “heada” (5 characters) to get. I would just simply type in “18.”

I have been working with Irena (Weight, Vice President of Protocol, Translation, Curriculum & Instructional Design) to clean up the Sub-CC and KQ1 lists. The following was or is being done:

1. Modified the name of “Solitary motorcycle” to “Motorcycle (solitary)” since this is fairly likely as not to be the choice, and Motorcycle would probably be what they start typing in. We’ll see.
2. We also reordered several of the “Top 12” to make a bit more sense.
3. We moved “HIGH VELOCITY impact” higher in the lists.
4. We will add a comment colon after “HIGH VELOCITY impact:” to better delineate just what it is (this only happens in KQs).
5. Per item 4, we will also have to deal with the comment colon issue on the Sub-CC choices of HIGH VELOCITY and LOW MECHANISM, as they don’t as yet pop up a comment box in this pathway. I think they should be popped up, in essence, as the first KQ1 action. There might be others throughout the protocol. That will be a DevCore issue that we will look into this week.

I hope this gives you some guidance on your article. I will let you know as soon as the things mentioned as being imminent are done. The next planned maintenance release for ProQA™ medical, etc., will be October 17th as of now …

Thanks man ... Doc
Why does research matter to me?

Heather Darata

Research starts with a question. These questions come when looking at how to best serve our communities, adapt to new technology, abide by new laws, create healthy environments for our dispatchers, and best allocate responders.

Because of these questions, research studies are a big step in finding out answers to what’s working and what can be improved in the emergency dispatch profession. The facts and evidence from these studies hold the key to understanding challenges and unlocking innovation in the profession.

But we understand that research articles can also be intimidating and challenging to decipher unless you’ve brushed up on your lingo. Forget all of that.

The Academy has your back. Say hello to new ways to help you stay informed about what the Academy knows and is continuing to discover.

First, let’s start with our new Research Briefs. Each is a single piece of paper with information on both sides. That’s it. We’ve boiled down the current research about a single topic and included what’s most relevant. We’ve also included a section about how this research has been put into practice for real application.

When looking at the Research Brief, you’ll notice that the question being studied and its answer are included at the top of the brief. The takeaway message is illustrated in the pull quote and infographic on the left for easy readability.

Our audience for these Research Briefs is primarily emergency dispatchers. But we know that everyone in the communication center can benefit from browsing them.

The Research Briefs can be found in the right column on aedrjournal.org. Don’t worry that these will be hard to decipher. We promise that they won’t. Plus, you can get CDE credit by taking the quiz for each brief on the College of Emergency Dispatch (learn.emergencydispatch.org). There are two briefs with their associated CDE quizzes already translated into German and one in French and Italian.

But it’s not just the roll out of the Research Briefs that we’re excited about. With over 25 episodes of our Dispatch in Depth podcast already available on the AEDR website, you can imagine the diversity of topics and guests available for your listening pleasure. The podcasts offer accessible information about the emergency dispatch profession—sometimes in 30 minutes or less. They come out every two weeks, so subscribe to keep them coming your way by visiting aedrjournal.org/subscribe-to-podcast.

Visit the College of Emergency Dispatch to take a quiz for each podcast listened to in order to earn sought-after CDE credit.

Want an easier way to stay in the loop on everything the IAED™ is doing with research? Sign up to receive our weekly newsletter by visiting the AEDR website and looking for the subscribe button on the top right. Want to know when the next podcast is being released? Want to participate in surveys? Curious what the next Research Brief covers? Subscribe to the newsletter and be in the know.

To dip your toes in the water, check out the research posters (aedrjournal.org/posters) as a way to visually find out more about topics ranging from MPDS® Protocol 26 and Protocol 10 to comparative location testing, superusers, and giving dispatchers “the rest of the story.”

Also visit our frequently asked question section (aedrjournal.org/learn) to find out how to understand a research paper, the difference between quantitative and qualitative research, and what to know about figures and tables.

If you want to get involved in doing research, send an email to ResearchHelpDesk@emergencydispatch.org and get the ball rolling.
WHEN SECONDS DON’T COUNT
Interrupting the caller isn’t always necessary

Art Braunschweiger

This morning on the way to work an impatient driver passed me, only to end up just two cars ahead of me a mile or two farther on. I’m used to that. Where I live—in New Jersey (USA)—we have some of the most aggressive drivers in the country. (In my travels, nearly a lifetime of driving here has stood me in good stead on the German Autobahn and the Italian Autostrada despite their own formidable reputations.)

Impatience can get us into trouble. On the road it can get us a ticket or get us killed. In 911 it can cause us to miss key information. Here is my perspective on when and why it might be beneficial to curb that impatience and listen for a few extra moments.

“Okay, tell me exactly what happened.” This is arguably the most important question we ask in our interrogation of emergency callers. But do you ever find yourself interrupting your caller as soon as he or she gives you the Chief Complaint? For many of us, the following is all too typical after asking the above question:

Emergency Dispatcher: “My husband started feeling nauseous and dizzy this morning—”

Emergency Dispatcher (interrupts): “Okay, ma’am, we’re sending an ambulance to help you. Are you with him now?”

If the caller wasn’t interrupted, she might have added “—after he was running the generator in the garage for a while.” Clearly that additional information would change the protocol choice from Protocol 26: Sick Person (Specific Diagnosis) to Protocol 8: Carbon Monoxide/Inhalation/HAZMAT/CBRN, and almost certainly require a fire department response in addition to EMS.

As new Q’s are taught, 95 percent of calls are not seconds-critical. Taking 45 seconds versus 83 seconds to dispatch a chest pain call is not likely to make a difference in patient outcome. Many times callers volunteer key information immediately after our opening statement before they give the address. We train new emergency dispatchers that the address and callback is paramount and to obtain it before all else, and the rationale behind that is obvious. But is it really necessary to interrupt callers every time they’re giving us good, solid information? If you answer with “911, what’s the address of the emergency?” and the caller starts to tell you exactly what happened, why not just listen for another few seconds (providing the caller isn’t rambling on) and then ask for the address? Technically that might delay your call entry, but you might make that time up a few questions later when you come to the “What Happened?” question in Case Entry since the answer might be obvious by that point. Interrupting isn’t always necessary and can actually add time if the caller has to repeat part of what he said.

Don’t be too quick to cut your caller off before he or she has finished answering a Key Question, either. Often what comes at the end of an answer changes what was said at the beginning.

Let’s remember, too, that finding out what happened is vital. “I’m having some kind of problem with my heart” doesn’t tell you, and we don’t clarify statements like that as often as we should. “What exactly is bothering you?” or “What kind of problem are you having?” are perfectly appropriate clarifiers. In some cases it might even be necessary to ask “What is she doing right now?” or “What was he doing just before this happened?” to determine the correct protocol to use. Neither are freelance questions. They shouldn’t be asked automatically, but on some calls they’re vital so we aren’t handicapped by not having the full picture.
ATTITUDE REFLECTS LEADERSHIP
Leader’s actions speak louder than words
Andre V. Jones

My manager told me once that by listening to radio traffic he knew who the supervisor on duty was in the dispatch center. He said there was something about their aura that had the ability to control the temperament in the room. When I actually considered it, he was correct; the attitude of employees is a direct reflection of their leadership.

H having worked with many different types of supervisors in the dispatch center over the years, it takes a unique individual to manage internal and external crises, simultaneously. It’s important to acknowledge the latter because senior managers and even executives often forget that the role of the supervisor is not exclusive to managing incidents but also managing people—people who have emotions and needs beyond their duty. The people are what make the organization what it is.

It takes a unique individual to manage internal and external crises, simultaneously.

I was listening to Las Vegas Fire Combined Communications (Nevada, USA) Supervisor Letha Lofton describe her actions on the day of the Route 91 Massacre (Oct. 1, 2017, when a single gunman opened fire on a crowded music festival). In that brief presentation at NAVIGATOR 2018, she displayed exemplary spirit, tenacity, and grace.

Lofton said her team was initially confused, overwhelmed, and helpless. “Baby, I got you,” she told them, and in that moment, it was all the support needed to bring out the best in her team. They were no longer hopeless because they all had an incredible guardian that moved out of the way to allow them to stay strong for each other.

Lofton’s composure kept her team together that night. Yes, the team members do have individual operational and coping skills, but I believe they were activated and guided under the support of her leadership. I believe in that situation, the supervisor switched from task-oriented to relationship-oriented, allowing fortitude, solicitude, endurance, and perseverance to thrive that night. Under similar circumstances I have seen supervisors escalate the crisis by trying to be too participative and directive. Lofton showed us that empathy and compassion inspire.

Sarah McCrae, Las Vegas Fire & Rescue (LVFR) Assistant Fire Chief, who arrived at the center within the first hour of the incident, commended the strength of Lofton’s team that night during her remarks at the NAVIGATOR Opening Session. “That night, our team undeniably had vision, they knew what they were after and what they were about. And so despite the fear, the concern, and the confusion, they pressed ahead and provided calm reassurance to our community and our first responders.”

So what type of leader is best for the emergency dispatch center? Any leadership style that can create an effective team. Fellow leaders, ask yourself:

• Do you have a purpose, and are you accomplishing it?
• Are you providing satisfactory leadership to your employees, customers, clients, and society; are you motivated and coordinated?
• Can you adapt to new opportunities and minimize obstacles (do you embrace change)?
• Are you capable of developing your own tasks and abilities?
• Would you survive in a world of uncertainties (resiliency, continuity)?

A good leader can assess and diagnose talent to see that the right people are doing the right jobs. A good leader can empower the team by enabling the team members to navigate and respond to change. Good leadership encourages interaction and communication among members, a shared understanding, goals, interest, and mutual positive attitudes. Heart, intellect, and improvisation are resources to make the right decision and get the job done. Ultimately, leaders take responsibility for the results.

Operational effectiveness hinges on team confidence. In a technical and tactical job like emergency dispatch, the team must be empowered to use what they know and practice. That is where the leader comes in. Are you the leader of an effective team?
Who knew that a small patch of dirt and some seeds could bring so much joy? For those of you who are gardeners, you completely understand the unique and powerful peace that growing your own food can bring. A community garden for dispatchers is not only a source of healthy food options for staff, but it has also promoted mental health and wellness as they work together toward a common goal—growing goodness in the midst of a sometimes stressful and negative work environment.

It started earlier this spring during a recent stroll through our break room. There were colorful signs posted on the bulletin board encouraging our folks to make good choices and to eat healthy! I turned and chuckled to myself as I saw three empty pizza boxes perched atop the trash bin. And then I peered out at the patch of grass growing right outside our back patio at the dispatch center. It was a perfect spot to grow a garden. It could be a way to encourage healthy eating and could even double as a stress reducing opportunity for staff!

As we moved through the growing season, staff talked excitedly about the little green tomatoes that were visible and the fact that the beans were nearly ready to pick. The garden journey was so positive for our center in many ways, and I encourage other agencies to consider following the same path. Here are a few tips to get you started.

**How does your garden grow?**

**Select your green thumbs**

It is always good to seek out those with the most knowledge about planting and appoint them as “garden managers.” These folks were key in deciding what we were going to plant and were the point people for the garden management and upkeep.

**Invest**

We enlisted our county parks division who was more than happy to assist in preparing the soil and placing a small fence around the garden. Comm. center management bought the seeds and plants, and they worked with the garden manager to do the planting.

**Start small**

Select a location close to the building. In our case, we planted the garden close to the back patio, where people enjoy the outdoors on their breaks. This encourages them to help by picking a few weeds or watering for a few minutes. After all, it is a center-wide initiative!

**Weed and water**

The garden had lots of helping hands who used their break times to weed and water. The garden managers made sure it got done and directed staff when needed/necessary. Everyone took the responsibility of shooing rogue bunnies away when they were found sneaking in to nibble on our plants. Honestly, this was not a significant workload, and with so many helping hands, the upkeep was manageable and minimal.

**Bountiful harvest**

As we watched the greens grow in the garden and saw the baby veggies coming to life, we could almost taste the fresh salads! Our staff shared the harvest, and we decided to bring some of the excess harvest to local shelters and/or food pantries.

We all know that dispatching can be stressful and understand the importance of having our folks simply step away from the madness if only for a few minutes. The community garden is pleasing to both the eye and to the palate. It provides a positive outlet; it’s an opportunity to be part of the cycle of planting, nurturing, and harvesting. It helps us to take a moment to breathe.

As May Sarton so eloquently quoted, “Everything that slows us down and forces patience, everything that sets us back into the slow circles of nature, is a help. Gardening is an instrument of grace.”
NEWBORN RESUSCITATION

Why the different ratios between MPDS and ILCOR?

Brett Patterson

Brett:

I had this inquiry from a senior midwife [Suzie Dunstan]:

Having recently been asked to listen in to a call where an EMD was giving resuscitation advice to a parent resuscitating a newborn baby, I became aware that your EMD Protocols differ from the International Liaison Committee on Resuscitation (ILCOR) Guidelines. The ILCOR advise a rate of 3:1 whilst the EMD Protocol is 5:1.

I understand from one of your paramedic staff here that there is also a difference between the ILCOR Guidelines and the EMD in the ratio for resuscitating children.

Many thanks.

Suzie Dunstan
Senior Midwife
Plymouth Hospitals NHS Trust
Plymouth, England

From what I [Dr. Andy Smith] can see:

**MPDS**
- Newborn/neonate < 30 days: 1:5 ratio of breaths to compressions
- Infant < 1yr: 2:30
- Child 1–7yr: 2:30
- Adult > 8yr: 2:30

**ILCOR Pediatric BLS**

All providers should be encouraged to initiate CPR in children even if they haven’t been taught specific pediatric techniques. CPR should be started with the C:V ratio that is familiar, and for most, this will be 30:2. The pediatric modifications to adult CPR should be taught to those who care for children but are unlikely to have to resuscitate them. The specific pediatric sequence incorporating the 15:2 ratio is primarily intended for those who have the potential to resuscitate children as part of their role.

The recommended compression to ventilation ratio for CPR remains at 3:1 for newborn resuscitation.

Any comments?

Kind regards,

Dr. Andy Smith,
Executive Medical Director
South Western Ambulance Service
NHS Foundation Trust, Exeter, U.K.

Greetings Dr. Smith:

You are correct. The ILCOR Guidelines address untrained laypersons, trained laypersons, and various providers—there has been very little mention of dispatch pre-arrival instructions until recently. The International Academies of Emergency Dispatch closely evaluates these published guidelines and “translates” them to the non-visual realm of dispatch. The Academy has a special Obstetrics Council that considers childbirth and neonatal care.
While trained rescuers are taught to provide a 3:1 compressions to ventilations ratio for neonates using the encircling hand/double thumb compressions technique, without the classroom training, this technique is not practical for the untrained rescuer in a non-visual environment. Not only is it difficult to instruct and understand in the emergent and non-visual environment, it is difficult to carry out with a single rescuer without very significant pauses in compressions.

There are as many differences between DLS (Dispatch Life Support), trained layperson first aid, and BLS, as there are between BLS, ALS, and in-hospital care, most commonly because of the non-visual nature of our practice, and also because of the inherent lack of time to train in an emergent situation.

You may be interested in some of the dispatch-specific articles on the IAED™ website under the Science tab (emergencydispatch.org) and articles on aedrjournal.org.

Please let me know if I can be of any additional assistance.

Brett Patterson
Academics & Standards Associate Chair, Medical Council of Standards International Academies of Emergency Dispatch

Brett:
We are configuring our ProQA® in preparation for upgrading from v13.0 to v13.1 and got a little confused with Determinant Descriptor 24-A-1. Under Determinant Descriptor, it states, “OMEGA protocol only: 1st TRIMESTER hemorrhage or MISCARRIAGE without 1st party verification -> 1st TRIMESTER hemorrhage / MISCARRIAGE without 1st party verification.”

The change from “or” to “/” is clear enough, but we don’t understand the “OMEGA protocol only” part. Shouldn’t anything that is an OMEGA be “O,” as in 24-O-x?

I’d also like to confirm that the only changes/adds are to Protocols 12, 23, and 24? Are we missing some or are there really just these few?

Thank you for your time.

Michael Dickerson, Supervising Public Safety Dispatcher Ventura County Fire Department Camarillo, California, USA

HI Michael:
The OMEGA protocol is actually another version of the MPDS that has additional OMEGA codes, most of which are ALPHA-level codes in the MPDS. The OMEGA protocol version is used in centers that have referral endpoints established, are accredited, and have chosen to use the OMEGA version. When we do updates, we need to include those minor differences to cover both protocols.

And yes, v13.1 is a limited release in ProQA only. Due to lengthy production times, the Academy will now be releasing smaller updates on a more frequent basis. In that way we can prioritize the changes and be more responsive.

Brett

Brett:
My EMD-trained dispatch student inquired how to approach a medical call from a woman who was assigned male at birth or a man who was assigned female at birth.

Many EMD questions, Protocols, and PDIs are obviously gender/sex specific, e.g., pregnancy. Do you question/address the caller as per their actual physical sex or by their preferred gender identity?

Stephan Bunker, Maine E911 Advisory Council and PDC™ Instructor

HI Stephan:
The Academy reached out to three transgender advocacy groups in an attempt to address this question, and we received one detailed reply. Unfortunately, this is a complicated issue due to the various surgical/hormonal stages an individual may be in at the time of an emergency call. So the long and short of it is we decided not to “protocolize” the issue due to the potential variance.

The good news is that there are some constants. First of all, refer to the patient based on how they identify. This is very important, no matter what the patient’s clinical state is. The biggest difference between gender in the MPDS is the use of she versus he, so identity becomes key here.

Fortunately, with the exception of pregnancy (specifically, questions qualified by childbearing age range), the protocols’ clinical differences are primarily related to cardiac age range, and this difference is relatively subtle in the MPDS and not likely to be an issue when using the patient’s birth sex. And with regard to pregnancy, it is appropriate to ask questions qualified by “female” when the patient’s birth sex is female, as these questions do not ask directly about pregnancy and are in no way offensive to someone identifying as male.

Always respectfully refer to the patient by gender identity.

The only potential conflict I can see is a female born patient who identifies as male complaining of abdominal pain. By Rule, abdominal pain during pregnancy should be considered contractions until proven otherwise. But even this should not be problematic because pregnancy needs to be offered in this scenario; the protocol does not ask if the female patient in childbearing age range is pregnant because of the historical inaccuracy of the answer provided. In other words, pregnancy needs to be offered by the caller before this Rule applies, and if the patient offers pregnancy, the Rule does apply.

So, in summary, use the patient’s birth sex for protocol interrogation but always respectfully refer to the patient by gender identity. Thanks for the question.

Brett
W
hen you enter the Lee County 9-1-1 Emergency Dispatch Center in Southwest Florida (USA), call sign “Lee Control,” you will hear music. Most would call our music chaotic noise because of phones ringing, people talking, computer keyboards clicking, and odd tones coming from small black boxes. Those sounds may seem like chaos, but our Lee Control family is unique. We are musical conductors or maestros, turning these sounds into a beautiful symphony that saves lives. Lee Control is a secondary 911 Public Safety Answering Point (PSAP) receiving calls for medical and fire response from the four primary law enforcement PSAPs in Lee County.

Lee Control emergency dispatchers, just like musical conductors, guide and instruct callers (our audience) using Emergency Medical Dispatch and Emergency Fire Dispatch Protocols to complete a musical score. The radio emergency dispatcher distributes the musical score to the orchestra, who are the paramedics and firefighters, and they, in turn, use their instruments to create a magnificent melody to save a life.

As a Lee Control emergency dispatcher, our technique in directing the audience and orchestra is motivated by the ballad, or situation. We set the tempo in hopes of bringing each musical score to a positive completion. The tempo can be slow, fast, or even supersonic and change quickly. We inspire our callers to move at our tempo whether it is performing chest compressions or checking a pulse. We train our ears to hear every note said by the caller or road crew. We never miss a beat as our right hand moves over the keyboard, our left hand answers the phone, and our foot keys up the radio. We end every performance, a 12-hour shift, exhausted but exhilarated with the knowledge that together we created a masterpiece of music.

Our dispatching ensemble came from humble beginnings. Lee Control was established in October 1971 to dispatch the Lee County Fire Control District that was made up of three fire stations. There was only one emergency dispatcher on a 12-hour shift, using pen and paper and working out of long forgotten military living quarters at Page Field Airport. The United States Army Air Force used these quarters during World War II to train B-24 bomber pilots as they patrolled the waters of the Gulf of Mexico looking for enemy submarines.

We began in modest, unassuming surroundings with awe-inspiring history. In 1972, Lee County purchased a private ambulance company and Lee County
Emergency Medical Services (EMS) was born, adding to the Lee Control ensemble. As the county grew, Lee Control and Lee County EMS began looking for new accommodations large enough to house both departments and protect them during hurricanes. The perfect location was a bomb shelter built for the Civil Defense Organization in the early 1970s due to the Cold War era. The building’s original intent was to house the local government following a nuclear attack. If it could withstand a nuclear attack, it could surely withstand a hurricane. Shortly after moving into the bomb shelter, the Civil Defense Organization developed into Lee County Department of Public Safety made up of Emergency Management, EMS, and us, Lee Control.

The year Lee Control began, the county population was 117,855 and growing quickly. In 1983, Southwest Florida Regional Airport was completed and our growth increased even more.

Lee Control kept up with the increasing population, and two emergency dispatchers per shift soon became four. Prior to 1987, all Lee County agencies received emergency calls via seven digit phone lines. The county began the research to add the 911 system and found there was Enhanced 911 (E-911) on the horizon. We decided to wait for the new system, and Enhanced 911 arrived in Lee County on April 7, 1987.

Certain years and events in Lee Control’s history stand out, and 1994 is one of them. Lee Control emergency dispatchers put away the pen and paper and began using a CAD system. Since we dispatch for EMS and fire departments only, Intergraph Corporation designed a CAD specifically to meet our needs. We now had six emergency dispatchers during the day and five during the night.

Early in 1997, Mobile Data Terminals (MDTs) were installed in the ambulances. Lee Control emergency dispatchers had to only activate station tones over the radio, read off the address, and with the touch of a button, we sent all information to the crews without having to say another word. We felt we would be obsolete and worried our skills were being replaced by a computer.

In 1999, Automatic Vehicle Locators (AVLs) were installed in ambulances and integrated with the CAD system. This innovation ensured we were sending the closest ambulance to every emergency. The fire departments began following suit and installing MDTs and AVLs in their vehicles. With all the upgrades, we knew we were creating a masterpiece.

In 2007, Lee Control began the process to become a medical Accredited Center of Excellence (ACE) with the International Academies of Emergency Dispatch (IAED). In March 2009, we achieved our goal. Shortly after reaching our first ACE, we began working on achieving our accreditation for Emergency Fire Dispatch (EFD), and in October 2012, we became a dual ACE (medical and fire). We are very proud to be in a small, elite group of 32 agencies around the world who are dual ACE accredited.

Another amazing honor was having our Lee Control emergency dispatchers recognized and receiving the prestigious Phoenix Award from Lee County Public Safety for saving a life. The award honors the coordinated efforts of first responders from local fire departments, Lee County EMS, Emergency Dispatch, and the Sheriff’s Office to successfully resuscitate a patient in cardiac arrest.

Lee County is 785 square miles with a year-round population estimate of over 739,000. In 2017, we had an additional 1.3 million visitors during the winter months, and for the entire year we had 4.8 million people visit Lee County. We answered 233,831 calls in 2017. Today, we have 36 emergency dispatchers. We dispatch for 48 ambulances, 19 fire districts, and 7 specialty divisions. We monitor a minimum of 24 radio channels including the Air Traffic Control Towers for Page Field Airport and Southwest Florida International Airport.

It has been my honor and privilege to work at Lee Control for 27 years, and I have been lucky enough to see what makes Lee Control so unique. Our people and the culture we inspire is what makes us not only unique but also exceptional! We are not only dedicated to our jobs and the citizens of Lee County, but we are dedicated to each other, each person giving more than they get in return. We encourage a culture of friendship, kindness, compassion, acceptance, determination, and most of all, respect for each other. We encourage each other to dream big. We laugh together. We cry together. We trust each other. We have each other’s backs at work and in life. We rejoice in each other’s accomplishments and support each other during difficult times. There are 39 exceptional people in our Lee Control family. We don’t just celebrate our unique center. We celebrate our unique family, making beautiful music together every day!

We never miss a beat.

Sources
1. Jim Geren, Lee County Public Safety, retired
2. Roger Desjarlais, County Manager, Lee County, Florida
12. Chief Casey Allo, Program Manager – Lee Control, Lee County, Public Safety
THE TIE THAT BINDS
From darkness comes strength
Talley Johnson

The night of Feb. 7, 2018, the Richardson Police Department (PD), Richardson, Texas (USA), received a call that changed its history.

All of us have likely taken a call that began the way this one did. A voice in an apartment complex cried out for help. The screens lit, and the room filled with sound. Calls from residents all over the apartment complex poured in reporting gunshots and identifying a victim. Conflicting information on the exact apartment number created a challenge for emergency dispatchers, who worked intensely to pinpoint an exact location to get the victim help while keeping callers safe. With their help, officers made entry to the correct apartment.

Richardson PD was established in 1955 in the small city bordering the city of Dallas; it boasts a growing population of 113,347. The Richardson PD communication center handles calls that range from small-city worries, like parking complaints, to major incidents that come along with our proximity to a metropolis.

Our police department has grown over the years, to roughly 180 officers and 21 emergency dispatchers. A typical communications shift has five emergency dispatchers and a supervisor to handle the call volume and dispatch needs of the city. We are a close-knit family, being so few.

At the moment, we are housed in our backup center while a new public safety complex is constructed. It is a small room, where we have to watch how loudly we speak to avoid going over someone else’s radio or call. Richardson PD has worked numerous high-priority calls and officer-involved shootings, but in our 63-year history, we had never lost an officer.

“Shots fired. Officer down!” Those were the words coming over the radio on Feb. 7. We have all trained for the worst-case scenario, but it would be an understatement to say that training scenarios can’t prepare you emotionally for losing an officer. My stomach went cold. It didn’t feel real. When Richardson PD officers made entry, the suspect shot and killed Officer David Sherrard and trapped six more officers in the apartment with gunfire. There was no time for shock or hesitation. We couldn’t stop to cry. The rest of our officers, still trapped in the apartment, depended on us to be calm. We needed to work as a team and bring our officers home safely.

The 911 calls continued to pour in reporting additional gunshots as officers returned fire. Another co-worker and I answered the phones that night, documenting witness information with the
knowledge that each call would be crucial in court. Between the 911 calls, I notified SWAT to respond and sent out the proper pages for additional manpower.

Dispatch Supervisor Sherry Buford was working the fire channel that night due to staff shortage. Buford had already dispatched paramedics to tend to the initial victim when Officer Sherrard was shot. She flew into action, dispatching additional apparatus and calling for mutual aid from three different cities. The supervisor phone line rang repeatedly as police chiefs and off-duty officers received notification of the incident. Buford answered them and commanded two fire channels seamlessly.

“As a supervisor, I constantly stress and model working together calmly as a team,” Buford explained. “Teamwork means asking for help and accepting help from others when offered. I am so proud of how everyone pulled together and helped each other during this incident. We received compliments from both the police and fire personnel regarding how calm and professional everyone sounded throughout the event.”

Teamwork during this time was crucial. Questions and updates cut through the din of phone calls.

“Find out which engine is filling in for Station 3,” Buford called out.

“The DPS Helicopter is on the line and wants to know if we need them.”

“What is SWAT’s safe route?”

Emergency Dispatcher Matthew Taylor worked the police channel. He relayed any information needed and diverted all other traffic to secondary channels. As SWAT and off-duty units arrived, Taylor kept track of them and documented the incident as the trapped officers were extricated behind a shield. Taylor remained at the helm after his shift ended, unwilling to leave his units until SWAT had negotiated successfully with the suspect and had taken the suspect into custody.

“It was comforting,” Taylor recalled, “knowing that I could count on the others in the room to get done what was needed so I could focus on the incident.”

I cannot speak highly enough of the men and women working that night or the compassion they demonstrated.

Kathie Burke, second watch Emergency Dispatch Supervisor, had rushed to work upon receiving the page. She rested a hand on my shoulder and told me to take a quick walk around the center. I took the opportunity to calm my mind. All of us were running on adrenaline, but as adrenaline waned, the body and cognitive abilities slowed down. Away from the familiarity and comfort of the computer screens, I cried for the first time that night, but I was uplifted by the sound of repeatedly opened center doors. Off-duty co-workers had come to help. They plugged into the open computers and provided much needed relief by answering phones during the heightened call volume and dispatching non-emergency calls while providing emotional support and hugs. The small human gesture of physical touch was comfort that cannot be overstated.

As I returned from my walk, trying to collect my thoughts, I found I was needed in a different role. The flood of pages we sent to notify the department of the shooting had crashed the paging system. Additional pages were needed, but now we would contact backup the old-fashioned way. I went into an adjoining room with a small team of emergency dispatchers and began calling from handsets and texting on personal phones. Using these methods, we were able to phone in volunteers to relieve the fire department and keep the officers up to speed.

The entire incident lasted nearly four hours. At the end of it, we had faced the worst incident in Richardson PD’s history. We gave everything we had and showed exceptional teamwork, coordination, and compassion to one another. I like to think that we are now a stronger team and have forged a bond, having gone through the worst and come out stronger on the other side.

I would be negligent if I failed to mention that losing an officer can cause emotional wounds for any emergency dispatcher. After a traumatic call, it is common to feel guilt, fear, and anger. An emergency dispatcher may experience flashbacks or have trouble coming to terms with what happened. If you have experienced this, it is so important to seek help. Ask your supervisors to provide Critical Incident Stress Management (CISM).

Ask if your department offers free counseling. Therapy dogs are also a very useful resource after an incident like this. Do not be too proud to ask for help; you need to be emotionally healthy for your own sake and for your officers. Take care of yourself and your team to stand against the dark days.

It would be an understatement to say that training scenarios can’t prepare you emotionally for losing an officer.

Sources
ENHANCED TOOLS GET YOU THERE FASTER
New features highlight life and breathing

Audrey Fraizer

When the International Academies of Emergency Dispatch® introduces changes to ProQA® including new features, we want our members to know about it. So go ahead and read on to find out about the Breathing Verification Diagnostic Tool, Smart DLS Links, and Smart AIs.

Breathing Verification Diagnostic Tool

This tool’s new title—“Breathing Verification Diagnostic Tool (BVDxT)” in the Medical Priority Dispatch System™ (MPDS®) version 13.1—says it all.

The diagnostic (previously known as the “Agonal Breathing Diagnostic Tool”), available since MPDS v11.2 in 2004, now has a name that more accurately describes exactly when the tool should be used.

“The tool was always meant to simply verify effective breathing,” said Brett Patterson, IAED™ Academics & Standards Associate and Medical Council of Standards Chair. “But, somewhere along the line, it started being applied when the caller was uncertain about the patient’s breathing status or even when the caller reported INEFFECTIVE or absent breathing.”

To clarify, the EMD should use the diagnostic in cases when the caller indicates that an unconscious (collapsed) patient IS breathing, but the EMD wants to VERIFY that the reported breathing is effective, or the EMD suspects the reported breathing might be agonal. Note that the BVDxT symbol has been moved from the end of Case Entry Question 6, “Is s/he breathing?”, to the “Yes” answer option of the same question to strengthen this directive.

The EMD should not use the BVDxT when the patient is unconscious and the caller answers “No” to the Key Question, “Is s/he breathing?”, when the caller reports UNCERTAIN BREATHING (uncertain, unsure, indefinite, or even ambiguous about breathing), or when the caller offers any of the keywords associated with INEFFECTIVE or AGONAL BREATHING. In any of these cases, the EMD should assume the patient has INEFFECTIVE breathing and begin CPR instructions immediately.

By Rule, also note that MPDS v13.1 now clarifies that it’s no longer necessary to use the BVDxT when it
is obvious that the seizure patient is actively waking up.

The changes are incorporated into ProQA.

It cannot be overstated that the BVDxT should be used to confirm that breathing is truly present rather than confirm already stated ineffectiveness of breathing, Patterson said.

As Dr. Jeff Clawson, Chair of the IAED Rules Committee, sums it up, “Use the BVDxT when you are unsure, not when the caller is unsure, and remember, as stated by Isabel Gardett, IAED Director of Academics, Research, and Communications, ‘If they don’t say yes, you must compress!’”

Smart DLS Links

ProQA has made it faster and easier to select the DLS Link for streamlining the patient’s EMS journey beginning at dispatch.

Called “Smart DLS Links,” the new feature logically prioritizes DLS Links based on the patient’s answers to Key Questions and directs the emergency dispatcher to the most suitable instruction from the list generated. Where more than one link applies, they are also highlighted with the green cursor arrow on the one most likely needed first, but the emergency dispatcher can choose.

The update applies to medical (version 13.1), fire (version 7.0), and police (version 6.0) protocol.

The links have always been available from the Post-Dispatch Instructions screen. The new platform simply ranks the DLS Instructions according to the caller’s targeting conditions (such as safety and presenting medical symptoms).

Smart Links changes nothing within the protocol evaluation and Determinant Code selection process and operates on the “facts” of each particular call, PDC Programmers Bruce Tenney explained.

“They’re [Smart Links] generated based on the data entered,” he said. “It makes the process more dynamic by moving the emergency dispatcher forward to the most appropriate Pre-Arrival Instruction without breaking the flow.”

For example, a caller asks for medical attention following an assault in which he was stabbed in the upper arm. He is bleeding profusely through the wound. The caller reports a suspect is still in the area but unable to say where.

In this case, Smart DLS Links prioritizes scene safety first and control bleeding second. If the caller reported the suspect leaving the area, control bleeding takes priority.

PDC Proofreading and Logic Design Specialist Audrey Gonzalez developed the overall domain rule logic sequence based on ProQA data and feedback from the IAED medical review staff.

“Smart Links gets the emergency dispatcher to the right PAIs faster,” she said. “It doesn’t do the work for them but identifies the priorities from information they’ve already gathered along the way.”

Smart AIs

A new Smart Additional Information (AI) feature simplifies the task of finding the relevant definitions while in Key Questions (KQ).

The BVDxT should be used when the caller indicates that an unconscious patient IS breathing, but the EMD wants to VERIFY that the breathing is effective.

In the original process, all the Definitions, Lists, Axioms, Rules, and Laws on that specific Chief Complaint have been available through ProQA’s Additional Information tab. ProQA automatically switched to the AI tab when necessary and the emergency dispatcher scrolled through the section for help in categorizing an injury or area and to remember the way the situation is treated in comparison to others.

While the basis hasn’t changed, the ease in finding the information for determinant decision-making has.

Smart AIs use the built-in logic of ProQA to automatically select, reorder, and highlight relevant Definitions (and occasionally Classifications/Information/List sections) to complement specific KQs. The highlighting/re-ordering is displayed the same time the KQ is, and the dispatcher can consult that to select the correct KQ answer. There’s no need to search through the entire AI tab. It’s brought right to the top of the AI section and is automatically highlighted to easily see.

We can use Protocol 3: Animal Bites/Attacks as an example. KQ 1 asks “What kind of animal is it?”, and ProQA automatically reorders and highlights the EXOTIC animal definition. Selecting an answer choice means that ProQA moves to the next KQ. The information highlighted helps more accurately determine the Determinant Code in consideration of other factors such as the patient’s condition, the animal’s size, and the number of animals involved.

Smart AIs do not highlight specific Rules/Axioms at this point, but may in the future.

Smart AIs are available in MPDS v13.1 and PPDS® v6.0 and will be available in FPDS® v7.0.
Agenda integrates EMD into total health care package

Audrey Fraizer

You’ve heard the saying, “Put your money where your mouth is.” In other words, act on what you say if you want your words taken seriously.

It can be a circular argument, particularly when there’s no money to support even the best intentions. Without appropriate funding, the words die on the vine.

That’s what stalled—for many agencies—the vision of EMS published in 1996. The problem was solved, partly through a federal initiative and a lot through agency ingenuity, to corroborate an updated vision of EMS for the year 2050.

EMS Agenda Envision the Future (1996)

The 1996 preamble proposed a community-based health management EMS fully integrated with the overall health care system. Development depended on “redistribution of existing health care resources,” and EMS would “remain the public’s emergency medical safety net.”

Unfortunately, there was little funding available to satisfy the ambition until nearly 15 years later.

A fully integrated system, however, is the way it has to be, according to EMS providers.

“As health care evolves, we have to develop ways to integrate EMS into the rest of the system for better patient care and outcomes at reduced costs,” said Brenda Staffan, Chief Operating Officer of Healthcare Services, Regional Emergency Medical Services Authority (REMSA), Washoe County, Nevada, USA. “It’s the future of health care.”
into the future
REMSA and MedStar Mobile Healthcare, in Fort Worth, Texas (USA), are both on the forefront of EMS innovation with programs designed to meet community health needs. So far, they are receiving high marks from both the health care providers along the continuum of care and the public.

And the story takes off from the historic, dramatically game-changing, and controversial Patient Protection and Affordable Health Care Act (ACA) that President Barack Obama signed into law on March 23, 2010. The Act addressed more than a divisive health insurance program for low-income members and vulnerable populations. The ACA also encouraged development of innovative health care delivery models that could and did accelerate coordination across the continuum of care.

The Center for Medicare and Medicaid Innovation (CMMI), within the U.S. Department of Health and Human Services, established and funded up to $1 billion in awards and selected proposals most likely to achieve a triple aim:
- Reduce costs
- Improve population health
- Create better partner relationships

CMMI reinforced the 1996 proposal and, also, supported EMS into the future, as reflected in the preamble of the 1996 and EMS 2050 project (projected for release in 2018). It’s people-centered.

Reasons agencies applied for grants depended on several variables, including available funding and the independence to establish programs with fewer restrictions. REMSA developed and implemented its programs using CMMI grant money and created a sustainable base postgrant. MedStar used its own funding to generate immediate buy-in from insurers and providers associated with the programs established.

**REMSA**

In 2011, REMSA, a non-profit EMS provider serving Reno and northern Nevada, was one of 107 health care entities selected for a CMMI Healthcare Innovation Grant among nearly 3,000 applicants. It was the only one of six EMS agencies in the nation to receive the funding.

REMSA’s components—community paramedicine, alternative destination transports, and a 24-hour nurse health line—were introduced separately beginning in 2012 and, by 2016 (four-year grant), sustainability was projected well into the future. Staffan, former Executive Director of the California Ambulance Association (CAA), was project manager.

**Combining forces**

One patient’s story illustrates how the components work together.

Adam (name has been changed) was calling 911 two to three times a month and based on his medical complaint subsequently transported by ambulance to the emergency department. The emergency department physician easily satisfied Adam’s request without intervention and with full knowledge that the same treatment could have been achieved through a primary care provider.

He was calling 911 to get his medication refilled. The system’s hands were tied. Adam’s complaint—although not medically proven—qualified him for ambulance transport, and once in the emergency department, the physician was obligated to refill the prescription but could not...
make referral to a primary care provider. Adam wasn’t taking advantage of the system. He didn’t understand how the system worked.

“Like many, he wasn’t aware of the services available,” Staffan said.

Fortunately, REMSA was there for him and ultimately fostered his independence through the community paramedicine and the alternative destination transport programs.

REMSA’s community paramedicine program (launched in June 2013, year two of the grant) focuses on frequent users of EMS services and assists hospital discharge patients. It provides post-discharge services to patients at home from specially trained paramedics following myocardial infarctions, cardiac surgery, and patients with congestive heart failure and chronic obstructive pulmonary disease. Frequent users learn better ways to access health care.

In Adam’s case (a frequent user), a community paramedic helped Adam sign up for Medicare benefits, and through REMSA’s alternative destination transport program, Adam was introduced to the Community Health Alliance (a REMSA clinical partner), where he connected with a primary care provider.

The alternative destination transports (launched in December 2012, year one of the grant) gives patients options other than going to the hospital emergency department after advanced paramedic assessment in the field. This includes transport to urgent care centers, non-emergency care clinics, detoxification centers, and mental health facilities.

REMSA’s clinical partners peaked at 16 during the grant.

In addition, Adam was assigned to REMSA’s Hot Spotter program, an outreach service for low-acuity patients, which includes a 30-day period to assist in follow through. A community paramedic periodically checked up on Adam, making sure his needs were met.

Over the next six months, Adam dialed 911 once. “Since then, he hasn’t called at all,” Staffan said.

A possible extension for Adam is the third component: a 24-hour nurse health line, in effect since October 2013 (the grant’s second year), accessed through a dedicated seven-digit number or by calling 911.

REMSA and MedStar Mobile Healthcare are both on the forefront of community-centered EMS innovation.

Savings

While the grant amount and programs varied among recipients, REMSA turned its $9.1 million award into a program that generated notable savings.

According to the program summary:

Over the four-year grant, REMSA’s Community Health Programs saved $9.66 million in health care payments, compared to $9.06 million in program expenditures. By year four, the program achieved an 84 percent return on investment, avoiding $1.84 in payments for every $1 in expenditures. They exceeded the overall goal of improving access to appropriate levels of quality care by 40 percent and reducing total patient care expenditures by seven percent.

Savings were recognized from improving care and referral options and reducing unnecessary utilization of emergency and hospital services, including a decrease in the percentage of emergency department transports that were classified as low priority.

In addition, the first four years of the program resulted in:

- 6,202 emergency department visits avoided
- 1,024 ambulance transports avoided
- 104 hospital readmissions avoided

Note: Estimates were calculated based upon average charges from data provided by the Nevada Center for Health Statistics and Informatics (this was an independent evaluation REMSA contracted), in addition to CMS formal review.

Sustainable and expanding

The grant ended in 2016, but certainly REMSA interventions have met and exceeded the triple aim objectives.

The initial three programs are still in full force and expanding into other underserved areas, which, according to findings, were high users of the nurse health line and alternative destination transport programs.
transports. The Community Health Alliance, which is a federally qualified health center, is among 10 clinical partners in northern Nevada. Nevada Medicaid and Hometown Health (a not-for-profit insurance company) cover alternative transports costs for their clients, and a growing number of providers are referring patients to the nurse health line.

In addition, REMSA is helping to ease a shortage of emergency medical services in rural Tonopah in northern Nye County (between Las Vegas and Reno). In March, REMSA launched an exclusive seven-digit Nurse Health Line for residents and provides a locally-based community paramedic.

REMSA in the present is the forecast of the future. “As health care evolves, insurance won’t cover care that is unnecessary or care that could be provided at a lower cost,” Staffan said. “It’s the future of EMS to the benefit of the entire health care delivery system and the patients the system serves.”

MedStar Mobile Healthcare

Going above and beyond traditional EMS was a concept long considered, although cost prohibitive for most ambulance services due to the funding models in place.

“Community health was something a lot of us thought about, but it was difficult to get it going,” said Matt Zavadsky, Chief Strategic Integration Officer, MedStar Mobile Healthcare, Fort Worth, Texas (USA). “We relied on a fee for services transport to the hospital.”

Most insurance companies (federal and private) use a fee for service schedule on behalf of members to cover the cost of pre-hospital emergency care (basic and advanced life support). The Balanced Budget Act of 1997 established a national fee schedule under Medicare Part B, which private insurers more or less incorporated into their coverage plans. Reimbursement depends on transporting the patient to the hospital. Medicare does not reimburse ambulance service that does not result in hospital transport. An empty ambulance is non-refundable.

And whether the patient is in a car wreck or seeks medical attention for a sprained ankle, ambulances will respond when a 911 call is received. The expense associated with low-acuity calls, rising expenses, and flat reimbursement affects not only EMS. The entire chain of survival—from dispatch to hospital care—feels the pinch of high costs for inappropriate use of emergency medical care through system overuse and public misunderstanding.

MedStar came up with solutions, starting in 2009 with a pilot program to provide more appropriate services for frequent EMS callers.

But first, we’ll start with a recent project implemented in March 2018. It’s the first of its kind method to flip traditional federal, private, and nonprofit fee for service transport and Medicare’s ambulance pre-authorization requirements. In a roundabout way, MedStar is leaving the decision to the patient through an advance payment plan negotiated between MedStar and one of the area’s largest insurance providers.

Zavadsky calls it “out-of-the-box” innovation, similar to MedStar’s approach to create a community of vested providers and better patient outcomes. Instead of reimbursing MedStar using the traditional ambulance transport fee for service model, the insurer provides direct deposit per insured member, per
Zavadsky said the program fits EMS projection documents (1996 and 2050). “This model allows us to say, ‘It’s terrible this happened to you, but let’s get you to the most appropriate place.’ It’s people centered, and in the long run, payers and providers save money, and we’re creating much happier patients.”

**Start of something big**

The capitated fee plan for transport is the most recent innovation among MedStar’s many alternative “into the future” programs. The first, implemented in 2009, addressed a situation EMS agencies share nationally: frequent EMS users. In 2008, MedStar made 2,000 trips for 21 patients, costing $962,429 in ambulance charges and the majority of the bills went unpaid.

The high user targeted program, which MedStar funded, targeted 21 high users (15 or more 911 calls in 90 days), most of whom had co-morbidity health issues (such as heart failure, diabetes, COPD) and turned to EMS for help for even minor medical issues such a filling a prescription. Rather than continue the unnecessary transport to an emergency department, MedStar enrolled patients into a 90-day program and developed individual care plans that included scheduled home visits by Mobile Healthcare providers for medical assessment and care plan checks. They put a calendar at the patient’s home, mark off the 90 days, and hand out certificates at their graduation.

“We wanted to empower the patient, to help them take charge of managing their own health care,” Zavadsky said. “There were gaps in the system. They didn’t know how to manage their own health care.”

The program proved a success. Since July 2009, ambulance transports to the emergency department in the enrolled population have been reduced by 59.7 percent. It has also prevented 2,395 emergency department visits and 462 hospital admissions. The savings was $9.27 million in health care expenditures for ambulance, emergency department, and admissions.

A second successful program, implemented in 2012, is the Academy’s Emergency Communication Nurse System. Low-acuity 911 callers, determined through MPDS interrogation, are referred to a certified ECN in MedStar’s communication center who helps the patient find appropriate resources for their medical issue.

In the past six years, 8,281 low-acuity 911 callers have been referred to this program, and 33.4 percent of have had a response other than an ambulance to the emergency department. The savings was $3.2 million in health care expenditures for ambulance transport and emergency department expenditures.

Other programs under MedStar’s integrated health care umbrella include hospital readmission avoidance, hospice revocation avoidance, and a home health partnership.

Innovation and demonstrating the true value for EMS is the way of the future, Zavadsky said. “It’s taken 20 years to get EMS the direction it should go,” he said. “MedStar is still evolving and becoming more robust and more responsive to the needs of our patients.”

You can find a summary of MedStar’s Patient Navigation and Mobile Integrated Healthcare at medstar911.org/mobile-healthcare-programs.

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**Source**

SMALL-TOWN FLAVOR

Rural centers have unique challenges

Josh McFadden
Across the world, the International Academies of Emergency Dispatch® (IAED®) has more than 64,000 members in 46 countries using the Priority Dispatch® Protocols. More than 3,600 dispatch centers are part of the IAED and use these protocols, making up a total of 23 languages. It’s not hard to see that the emergency dispatchers come from a variety of geographic locations, backgrounds, and cultures.

While the Medical Priority Dispatch System™ (MPDS®), Fire Priority Dispatch System™ (FPDS®), Police Priority Dispatch System™ (PPDS®), and Emergency Communication Nurse System™ (ECNS®) are consistent and standardized
(except for some culturally appropriate terminology and wording changes) in all areas of the world, the centers themselves all have their own challenges.

While working in an urban dispatch center will have higher call volumes and may present more widespread emergency calls such as mass shootings, agencies in smaller areas have different trials for callers and emergency dispatchers. These can test the mettle and skill of veteran and newcomer emergency dispatchers alike.

Funding problems

It seems as though so many of the struggles in professional and personal life come down to money, and it’s no different in the emergency dispatching and emergency response world.

Public Safety Answering Points (PSAPs) everywhere rely on funding to help furnish up-to-date equipment and to hire additional staff. These sources come from local governments and from fees households and businesses must pay as part of their wireless and landline phone usage. In the United States, individual states usually collect the 911 fee.¹ In other states, a local government’s general fund may fund PSAPs, while other states that don’t collect such fees apply for grants.²

It’s no secret that more and more people are calling emergency numbers from cellphones. As we reported in the May/June issue of the Journal in the article “Cellphone Trouble,” 62.9 percent of everyone on Earth has a cellphone.³ According to the National Association of Counties (NACo) in Washington, D.C. (USA), 80 percent of 911 calls in the U.S. in 2015 were made from cellphones.³ This increase presents funding problems as well. For example, in the U.S. state of Kentucky, cellphone users pay only 20 to 25 percent of the total 911 fees, despite making 80 percent of the calls. These callers pay just 70 cents a month in 911 fees, and of this, 70 percent goes to the local areas, while the rest goes to the state. Thus, as more and more people use cellphones, counties and smaller municipalities collect less funding for 911 centers.⁵

NACo officials issued this caution: “[C]hanges in the telecommunications industry require PSAPs to implement costly upgrades in order to quickly locate and respond to callers. Concurrently, PSAP operators such as counties are receiving less in dedicated 911 funding, due to shifts in telecommunications preferences and states withholding fees that would otherwise be remitted to counties. Residents and counties are left in a position that may delay the delivery of lifesaving assistance.”⁶

Emergency dispatchers who work at rural centers are seeing the effects of lack of funding. Nichole Becker works for the Rangely Police Department, a small center in Rangely, Colorado (USA). She said her center has to compete for training and equipment funding with the police department’s other needs. This isn’t an easy task.

“Trying to get to the city council and explain what we do and how important we are to the community is tough,” she said. “We are always on the chopping block as far as a potential cost they could cut.”

Of course, agencies of all sizes throughout the world face funding challenges; this problem isn’t limited to rural centers. However, it can be more difficult to handle for smaller centers that are already at a disadvantage as far as resources are concerned.

Response times

Centers that serve higher-populated areas may handle far more calls, but rural centers usually respond to calls over large geographic regions. In some cases, agencies are responsible for vast coverage areas.

We've done CPR (over the phone) for an hour and a half. We are so remote. We get some volunteer responses, but not many.

The case of South West Queensland in Australia is eye-opening.

Marc Hauswirth is the supervisor at this agency, located outside of the desert town of Birdsville, population 140. Hauswirth said dispatching help to people in his jurisdiction can take hours. South West Queensland covers an area of approximately 164,500 square miles, or 426,000 square kilometers. To give you an idea of how enormous that is, South West Queensland is responsible for an area 8,500 square miles larger than the U.S. state of California (the third-largest state in the country) and significantly larger than all of Germany. Only 30,000 residents live in this spread-out area.

Hauswirth said it can take ambulances up to three hours to reach someone in need. He once worked on a call where the return ambulance trip was a staggering 14 hours.

“We’ve done CPR (over the phone) for an hour and a half,” he said. “We are so remote. We get some volunteer responses, but not many.”

It might be impossible to top Hauswirth’s experience, but other rural agencies confront their own long response times.

Muscatine County (Muscatine, Iowa, USA) Joint Communications Lead Dispatcher Christopher James said long medical responses can take a toll on the emergency dispatcher providing instructions.

“Sometimes our rural ambulances can take 20 to 30 minutes, if not longer, to get
to a specific call,” he said. “It takes time and energy for a dispatcher to give CPR or childbirth instructions for that long. And let’s not mention when you do it alone and other things are happening also. I have delivered babies and done CPR for what seems like hours on the phone waiting for someone to get on scene. I think living in the country can be beautiful scenery, but if something goes wrong, that is the price you pay: waiting for a response.”

James also said sometimes when he dispatches volunteer firefighters to a scene, they’re unable to get a full crew together so they ask James or a colleague to send out another volunteer group. This only increases wait times for people in dire situations.

“You page them out and then wait for them to get up, drive to the station, and respond,” James said. “It all takes time and sometimes can be a long time before someone reaches you.”

Kristen Anderson, emergency communications assistant manager at Confire Communications of San Bernardino County (California, USA), handles calls for a large county. She said it can often take hours to get help to a desperate caller. The center also relies on volunteers, which can create complications.

“Some challenges we’ve faced is dispatchers spending a ton of time calling co-operators to try to find anyone closer than what we have,” Anderson said. “A lot of the rural areas are paid call or volunteer and take time to get to the station and then get to the calls. Some have made up their own street names, and we have a lot of off-roading where people come from all over and have no clue where they are or how they got there.”

Help wanted

High turnover rates and difficulties retaining employees in emergency dispatch centers are always concerns at agencies of all sizes. For some smaller centers, simply finding potential help at the console isn’t easy.

Matt Halfacre, who works for the Bandera County (Texas, USA) Sheriff’s Office as assistant communications supervisor, notices this and said rural centers have a tough time attracting quality applicants. He said it’s not easy convincing people to pack up and move to smaller town with fewer resources and limited opportunities.

“In a rural area, especially one with relatively high property values (and thus, expensive housing), there is a significantly smaller pool of potential applicants,” he said. “Of the pool of actual applicants or interested people, there are even fewer who are rudimentarily qualified and almost none with any relevant experience. Because of the limited budgets that plague the entire industry, there is no good way to entice potential applicants from outside the area to consider relocating to the area, since they would be completely on their own with regard to moving and living expenses and since there is a dire need for qualified telecommunicators around the country.”

Though many of these rural agencies only employ a handful of emergency dispatchers, it can be a tremendous undertaking to replace someone when they quit or to fill in for a sick employee. Those who do work in these smaller centers put in significant hours and (like any emergency dispatcher) face mental, emotional, and physical fatigue.
“As of right now, we have the minimum number of dispatchers possible (eight), plus one trainee,” Halfacre said. “If anyone takes off or is sick, or is out for any other reason, an opposite shift dispatcher is forced to cover. The biggest strain lately has been lack of vacation time able to be taken.”

Close to home

There’s a good chance that emergency dispatchers who work in metropolitan areas won’t ever take a call from a family member or maybe not even from someone they know. However, when you cover an area of only a few thousand residents, at some point, you may hear some familiar voices calling for help.

Well-trained, capable emergency dispatchers are skilled at handling calls with professionalism and poise, no matter what needs the person has or who they are. Still, taking a call from a family member, friend, or neighbor requires some extra fortitude and courage.

Dispatcher Jordyn Clark, with New Haven Dispatch in New Haven, Indiana (USA), said the concern a loved will call is real.

“I’m constantly worrying that my family or friends may be involved in an accident, due to knowing a lot of the community I dispatch for,” she said.

Trecia Hanna, dispatch manager at MedStar Ambulance (a Medical ACE) in Sparta, Illinois (USA), said it’s not unheard of for emergency dispatchers at her center to face the challenge of sending lifesaving help to someone close to them.

“Anytime there’s a bad accident, we’re all taking stock of ‘where are the kids, husbands, wives?’ etc.,” she said.

“There’s been more than one occasion that while on duty one of my dispatchers has handled an emergency call involving a family member.”

People give directions by landmarks or "so and so's" farm. If you aren't from the area, it's near impossible to dispatch to a location at times.

What's the address of your emergency?

This is the first question you ask when someone calls into your center. Usually, this shouldn’t be a difficult question for the caller to answer. Unfortunately, it can be a little more complicated in remote places.

Frequently, callers in less-populated towns and counties won’t give addresses; instead, they’ll respond with other methods that aren’t always easy for emergency dispatchers to understand, especially if they haven’t lived in the area for long.

“In smaller towns with a high farm population, people give directions by landmarks or ‘so and so’s’ farm,” said Dana Bell, public safety communications manager with Taber Police Service in Taber, Alberta (Canada). “If you aren’t from the area, it’s near impossible to dispatch to a location at times.”

Other issues include duplicate addresses or even areas without addresses where the emergency dispatcher has to know whom the caller is talking about and where the person lives.

Hanna said the following types of directions aren’t uncommon: “Turn at the barn that burned down 20 years ago, go through three gates, watch out for the culvert, and don’t mind the dogs—they won’t bite!”

Back me up

Another common issue rural agencies deal with is sending backup on police responses. Though high-acuity police calls may be much less frequent than with medium-sized or large agencies, smaller municipalities have fewer resources to work with.

Emergency dispatchers who work in remote centers say backup could be more than 20 minutes away on these calls. Worse, some areas only have one unit on hand at a time, even though a two-unit response may be necessary. Iosco County (Michigan, USA) 911 emergency dispatcher Brianna Golden said there are times when not a single officer is available to go to a call. This creates significant challenges for the caller and others in need.

That’s a wrap

The list could go on, but it’s clear that dispatching and calltaking from rural centers can introduce a different set of challenges that larger agencies may not see as often or at all.

It’s also interesting to see the perspective of what it’s like to cover expansive areas and how emergency dispatchers adapt to long response times, lack of funding, familiar callers, and other trying circumstances.

Sources

2. See note 1.
4. See note 1.
5. See note 1.
73 seconds after liftoff on Jan. 28, 1986, at Kennedy Space Center (Cape Canaveral, Florida, USA) the NASA space shuttle Challenger exploded killing all 7 astronauts on board.³

362 miners died in an explosion in 1907 at the Monongah Nos. 6 and 8 Coal Mines in West Virginia, USA, in the worst coal mine disaster in U.S. history.¹

1,900+ people were taken to the hospital following two warehouse explosions in the Port of Tianjin, China, in 2015. The first explosion had a power equivalent of 3 tons of TNT detonating; the second explosion had the equivalent of 21 tons.⁴

12,000+ homes were damaged after the French ship Mont-Blanc exploded after being hit by the Norwegian ship Imo.¹

700+ people were injured and at least one person died after a tanker truck carrying flammable materials exploded when it crashed into a truck in Bologna, Italy, in August 2018. It took almost 2 hours for firefighters to put the fire out because of extremely high temperatures.⁶

1,900+ people died in December 1917 when the Norwegian ship Imo struck French ship Mont-Blanc, which was loaded with picric acid, gun cotton, benzol, and TNT. The Mont-Blanc was hit on the bow in The Narrows in Halifax Harbour, Nova Scotia, Canada. After burning for 20 minutes, the Mont-Blanc exploded.⁶

WHEN THINGS EXPLODE
Changes to FPDS version 7 enhance Protocol 57

Heather Darata

About 7 p.m. on Feb. 25, Leicester, England, residents heard a low booming sound and felt their residences shaking like an earthquake.¹ Startled, they went outside to discover a three-story building had collapsed like a pancake following a sudden blast. Gas and flames were streaming out of the building. Five people died—one working downstairs in the Polish grocery store and four people in the flat upstairs.²

Contrast that incident with the loud boom heard a month later in New York City, New York (USA). A manhole cover blew open, followed by a second manhole explosion down the block in downtown Manhattan.³ While there were no serious injuries in this case, these two incidents do have something in common. What you might wonder? They are both handled on Fire Priority Dispatch System™ (FPDS®) Protocol 57: Explosion. With the release of FPDS v7.0 coming up, this CDE will focus on this new version of the protocol.

Breaking down explosions
An explosion is defined as an incident involving the report of an explosion, seen or heard. Protocol 57 covers explosions in different locations, including buildings, vehicles, manholes, non-dwelling buildings or structures, open areas, mobile homes, portable offices, and house trailers. Emergency Fire Dispatchers must know the definitions included in the Additional Information section of Protocol 57 in order to decide which Determinant Code applies to each situation that comes up.

Key Question 1 asks “What has exploded?” If the caller answers that a building has exploded, the EFD will ask KQ 1a, “What type of building/structure is involved?” One type of building is a HIGH RISE, which is “a building (structure) that is too tall for adequate fire control from ground-based aerial ladders, elevating platforms, or towers.” Think tall office buildings in an urban setting. Each local dispatch and fire agency will define how tall a building (structure) must be to be considered a HIGH RISE.

A COMMERCIAL/INDUSTRIAL building is one “in which the primary purpose is to conduct activities of business, industry, or trade.” Each dispatch and fire agency determines its own definition of GOVERNMENT building, LARGE NON-DWELLING building/structure, and SMALL NON-DWELLING building/structure.

Something else EFDs need to take into consideration is whether
what has exploded is a HIGH LIFE HAZARD. It’s defined as “any location that poses multiple life threats due to difficulty exiting or lack of mobility of the inhabitants.” Examples include churches, hospitals, nursing homes, large apartment complexes, and schools. Buildings that meet the HIGH LIFE HAZARD definition receive the highest Determinant Code possible, 57-D-1.

But Protocol 57 isn’t just for building explosions.

New on Protocol 57 is KQ 1b, “What type of vehicle is involved?” Protocol 57 includes definitions for two types of vehicles. The first is COMMERCIAL vehicle, which is defined as “Any vehicle that transports products related to business or trade. The products can be dangerous or hazardous.” Two examples given for COMMERCIAL vehicle are tankers and tractor-trailers (semis). The other type of vehicle defined for EFDs is LARGE FUEL/FIRE LOAD vehicle: “Vehicles, usually large in size, that can carry large amounts of combustible materials. These may pose additional threats during firefighting operations and require additional resources.” Examples listed are campers, motor homes, and buses.

Early dispatch point

If the explosion involves a manhole, NON-DWELLING buildings or structures, open areas, mobile homes, portable offices, or house trailers, the EFD will move to KQ 2 “Is anything burning?” after discovering what has exploded. Following KQ 2, the EFD will dispatch responders for all dispatch codes. This allows the EFD to gather all pertinent safety information before dispatching and also allows responders to arrive as quickly as possible.

Protocol 57 has DELTA, CHARLIE and BRAVO Determinant Codes. Two of the three CHARLIE codes are new in version 7; “Other vehicle explosion” was previously a BRAVO-level code. Any buildings/structures, including NON-DWELLINGS and mobile homes, house trailers, and portable offices, receive a DELTA-level code. A COMMERCIAL vehicle receives a 57-D-9 and a LARGE FUEL/FIRE LOAD vehicle receives a 57-D-10. Other vehicle explosions are now dispatched as a 57-C-1. Open areas receive a 57-C-2 while a manhole explosion is coded as a 57-C-3.

Other explosions receive a 57-B-1 while Rule 3 instructs EFDs to code audible explosions without visible damage as 57-B-2 “Unknown situation (investigation).”

Protecting the caller

After dispatching, the EFD will return to questioning. After asking KQ 3 “Is anyone trapped?” and gathering additional information by asking KQ 3a and 3b, if applicable, the EFD will go to Post-Dispatch Instructions and then follow the Dispatch Life Support Links if the caller or others are trapped or in danger. The EFD will tell the caller not to touch or pick up anything, not to try to put the fire out (if applicable), and not to use, turn on, or turn off any additional electrical devices. Two additional PDIs have been added in version 7. PDI-e tells the caller, “If it’s safe to do so, leave the building, close the doors behind you, and remain outside.” For a COMMERCIAL/INDUSTRIAL/Multi-dwelling situation, the EFD will offer PDI-f, which instructs the caller not to use the elevator. Also, at this stage the EFD will advise the caller of potential hazards and let responders know of potential hazards and any information gathered regarding the number of people trapped or in danger and their location.

Mike Thompson, Priority Dispatch System™ Program Administrator—Fire and Medical, said it is statistically safer for the caller to evacuate a building or location after an explosion.

“When somebody is in a building or location where there’s a significant known problem or even an apparent problem, we are going to tell them to leave,” he said. “It’s become our philosophy that more often than not, it’s not safe to stay. When you stay in a location where there’s a problem, it’s probably a bad idea.”

After providing PDIs, the EFD will go to the appropriate DLS Link. Building/Structure Evacuation (1st party) (B-1) is new to version 7 of the FPDS. Other links include Caller Danger - Not Trapped (B-3), Trapped in Confined Space/Structure Collapse (1st party) (D-2), Stay on the Line (X-2), and Urgent Disconnect (X-3).

Continuing Key Questioning

If the answer to Key Question 3 is no, the EFD will continue with Key Questioning. The EFD will ask about the extent of the damage, if the caller heard a bursting or hissing sound, and whether anyone on scene has complained of an unusual odor. KQ 7 asks “Is anyone injured?” If the answer is yes, the EFD will ask KQ 7a “How many?” EFDs will need to see if the number of people injured meets their agency’s definition of MASS CASUALTY INCIDENT (MCI). An MCI is a “Medical/Trauma situation where the combination of multiple patients and injuries exceeds the immediate capability of the EMS system.” Within the definition, there is a space for agencies to include their definitions in terms of number and type of patients for Level 1, Level 2, and Level 3.

The final KQ on Protocol 57 asks if the caller saw anyone or anything suspicious. While in Key Questions,
ProQA® will immediately reconfigure the dispatch code to include the appropriate Determinant Suffix, when applicable. Three new Determinant Suffixes have been added (X = MCI Level 1, Y = MCI Level 2, and Z = MCI Level 3) and two have been reassigned (Single injured person is now V, and Multiple injured persons is now W).

Explosions of a terrorist nature

Mass casualty incidents are on the rise. In 2016, bombing/explosions accounted for 54 percent of attack types used in acts of terrorism worldwide.¹

One such example is an explosion on one of London’s (England) Underground trains in September 2017 during the morning rush hour. A single improvised explosive device exploded at the Parsons Green Tube station. At least 29 people were injured.⁵

Because explosions are sometimes used for nefarious purposes, Rule 1 on Protocol 57 reminds EFDs that all explosions are considered crime scenes and callers should be advised not to disturb anything.

Thompson said Protocol 57 was originally intended to deal with explosions that were not of a terrorist nature. “Now deliberate terrorist attacks using explosive devices have changed that,” he said.

Other explosions

What about those explosions you might not be too familiar with? Take, for instance, manhole cover explosions. Did you know that manhole explosions are frequent in New York City? There are, on average, six such events a day.⁶ Back in February 2015, Consolidated Edison, the city’s utility company, reported 600 incidents in one week involving fire, smoke, and explosions taking place in manholes.

The electrical system in New York City is the oldest in the U.S. and some underground wires are 100 years old. The perfect storm of road salt (used to melt snow and ice buildup) seeping into manholes and wearing away insulation that covers the underground wires, plus the city’s rats gnawing away at wires, can lead to sparks as the insulation heats. That creates a buildup of pressure that can spur the loud boom and send the manhole cover flying into the air. It is possible for electrical fires to start also.

For more than 10 years, Con Edison has been working to replace old manhole covers with ones that do a better job of ventilation. The city has a whopping 246,000 manhole covers, making the job no small task.

Choose your protocol

You might be familiar with the Medical Priority Dispatch System™ (MPDS®) and the Police Priority Dispatch System™ (PPDS®) in addition to the FPDS. The MPDS handles explosions on Protocol 7: Burns (Scalds)/Explosion (Blast), and the PPDS handles them on Protocol 117: Explosion. Thompson explained that agencies using two or all three of the protocol systems should review the protocols to understand what they do and do not do. The MPDS tends to be patient centric while the PPDS and the FPDS are situation and safety centric.

“They all do something just a little bit different,” Thompson said.

Then agencies should let their Dispatch Review Committee (DRC) decide when emergency dispatchers in their agency should use each of the protocols.

“From an overall point of view, the Fire Protocol does the best job with things like explosions,” he said. “It takes into account that someone saw an explosion and that’s all they may know.”

Sources

6. See note 3.
YOU MUST BE FIRE CERTIFIED TO TAKE THIS QUIZ

Answers to this quiz are found in the article “When Things Explode,” which starts on page 32. Take this quiz for 1.0 CDE unit.

1. Protocol 57 covers explosions in vehicles, buildings, mobile homes, house trailers, open areas, and which of the following:
   a. manholes
   b. non-dwelling buildings or structures
   c. portable offices
   d. all of the above

2. A HIGH RISE is defined as “a building (structure) that is too tall for adequate fire control from ground-based aerial ladders, elevating platforms, or towers.”
   a. true
   b. false

3. Each dispatch and fire agency determines its own definition of GOVERNMENT building, ___________________ and ___________________.
   a. LARGE NON-DWELLING building/structure, SMALL NON-DWELLING building/structure
   b. SMALL NON-DWELLING building/structure, mobile home
   c. LARGE NON-DWELLING building/structure, portable office
   d. SMALL NON-DWELLING building/structure, house trailer

4. Examples of a HIGH LIFE HAZARD include:
   a. churches and nursing homes
   b. large apartment complexes and schools
   c. small apartment complexes and single family homes
   d. a and b

5. After asking Key Question 2, the EFD will dispatch responders for all dispatch codes.
   a. true
   b. false

6. Which of the following CHARLIE Determinant Codes was previously a BRAVO-level code?
   a. 57-C-1 “Other vehicle explosion”
   b. 57-C-2 “Open area”
   c. 57-C-3 “Manhole (cover/underground vault)”

7. Rule 3 instructs EFDs to code audible explosions without visible damage as:
   a. 57-C-1 “Other vehicle explosion.”
   b. 57-B-1 “Other explosion.”
   c. 57-B-2 “Unknown situation (investigation).”

8. Which two Determinant Suffixes have been reassigned on Protocol 57?
   a. X = MCI Level 1 and Y = MCI Level 2
   b. X = MCI Level 1 and Z = MCI Level 3
   c. V = Single injured person and Z = MCI Level 3
   d. V = Single injured person and W = Multiple injured persons

9. In 2016, bombing/explosions accounted for _____ percent of attack types used in acts of terrorism worldwide.
   a. 9
   b. 25
   c. 54
   d. 78

10. Which protocols are situation and safety centric?
    a. MPDS and FPDS
    b. MPDS and PPDS
    c. FPDS and PPDS

To be considered for CDE credit, this answer sheet must be received no later than 10/31/19. A passing score is worth 1.0 CDE unit toward fulfillment of the Academy’s CDE requirements. Please mark your responses on the answer sheet located at right and mail it in with your processing fee to receive credit. Please retain your CDE letter for future reference.
WHEN YOU NEED IT MOST
MPDS v13.1 enhances ProQA script for drug overdose

Audrey Fraizer

Every revision of the Medical Priority Dispatch System™ (MPDS) is designed to incorporate the latest science in public health and emergency care for emergency medical dispatchers. Sometimes these changes reflect an undesirable trend in public health; such is the case for the dramatic rise in deaths from drug overdose—in particular opioid overdose.

And the EMD must be prepared with the proper set of lifesaving instructions when the callers and patients are in critical need.

MPDS version 13.1 contains revisions to Protocol 23: Overdose/Poisoning (Ingestion) to include a truly frightening addition to the synthetic drug world: fentanyl—and its chemical analog carfentanil. Fentanyl is anywhere from 50 to 100 times more potent than morphine, and carfentanil is up to 4,000 times more potent than heroin and 1,000 times more potent than fentanyl.1

It’s important to note that the revisions in MPDS v13.1 Protocol 23: Overdose/ Poisoning (Ingestion) exist only in ProQA® Paramount; they are not available in the printed cardsets. The updates include additional Key Questions and enhanced PAIs for Narcan/Naloxone administration:

- The operator question “Ø Any mention of Fentanyl, Carfentanil, or U4 (Pink or Pinky)?” has been added to prompt specific suffix coding for those drugs.
- Key Question 9 asks “Is there any Narcan (naloxone) available?”
- If Narcan is available, Key Question 9a has the EMD tell the caller, “Good, I want you to give it to her/him now.” Regardless of whether Narcan has already been administered, the EMD may give instructions for administering the opioid antidote if the caller requests help.
- A new Determinant Code has been added: 23-D-1 “Arrest.” The remaining DELTA-level Determinant Codes have been renumbered.

Instructions an EMD provides also depend on the availability of Narcan and the patient’s condition (not breathing, started moving, still unconscious, waking up now) following administration, with the possibility of subsequent doses based on the patient’s medical response. ProQA also provides detailed PAIs for auto-injection, including how to manage pre-filled syringes (needle on, off, or attached) and directions guiding the injection: straight into her/his upper arm or thigh, right through any clothes. Be sure to push the plunger all the way down to give it all.

Both ProQA and the cardset provide instructions to give an additional dose...
if there is no improvement in her/his breathing (respiratory function) in 2 to 3 minutes or if symptoms return after the first dose.

New to MPDS v13.1 in ProQA are several additional problem suffixes, including suffixes that identify accidental and intentional overdoses of either fentanyl or carfentanil.

**Carfentanil overdose and the delivery of DLS**

“First do no harm” is a fundamental principle of the medical profession. Given known dangers of carfentanil exposure to unprotected bystanders, the IAED™ issued an official statement describing the recommended emergency dispatcher actions when instructing bystanders when this substance is present around the patient (released June 28, 2017, and available at emergencydispatch.org). It states the following:

*The Emergency Dispatcher should be prepared to omit or discontinue all DLS instructions involving touching the patient if:*

- The caller spontaneously provides information that suggests the presence of carfentanil (powder or liquid) on or in the immediate area of the patient.

Or

- The caller questions the safety of touching the patient when a known (or suspected) synthetic opioid is present.

The Emergency Dispatcher may discontinue treatment with a statement such as, “This could be a very dangerous situation. Do not touch the patient or disturb anything around them. Wait for the paramedics and tell me immediately if anything changes. If you feel unsafe, leave the area and take the phone with you if you can.”

As always, and as expressed by Protocol Rule, “If the complaint description involves hazardous materials (toxic substances) that pose a threat to bystanders or responders, go to Protocol B.” It is not generally necessary in OVERDOSE cases, and should not be considered routine practice. However, it can be entirely appropriate if the caller provides information during Case Entry that suggests scene contamination is an imminent risk and the safety of the caller outweighs treating the patient.

In September 2017, the U.S. Drug Enforcement Agency (DEA) issued a public safety warning involving the extreme danger of even minimal contact with fentanyl and derivatives. Similar to the IAED advisory, the DEA cautioned against handling any substance suspected of containing the drug unless trained and outfitted to do so.

Even minor exposure to these drugs through skin contact or inhalation can send a healthy adult to the emergency room in respiratory distress. Personal protective equipment (PPE) such as nitrile gloves, an N-95 mask, eye protection, and coveralls are recommended for responders when treating known fentanyl-related overdoses.²

**International concern**

An analysis of opioid overdose deaths in 10 U.S. states participating in an Enhanced State Opioid Overdose Surveillance (ESOOS) found that illicitly manufactured fentanyl is a key factor driving opioid overdose deaths and that fentanyl analogs—similar in chemical structure, such as carfentanil—are increasingly contributing to significant public health implications. Estimates of U.S. drug overdose deaths exceeded 60,000 in 2016 and were partially driven by a fivefold increase in overdose deaths involving synthetic opioids fentanyl and carfentanil (excluding methadone), from 3,105 in 2013 to approximately 20,000 in 2016.³

Synthetic opioids are not isolated to substance abuse in the U.S.

In July 2017, the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA) issued a warning regarding carfentanil due to increased confiscations and fatalities in several European Union member states. According to a report of the World Health Organization (WHO), deaths with confirmed exposure to carfentanil were reported by Belgium (1 case), Estonia (6), Finland (1), Lithuania (7), Norway (1), Sweden (3), and the U.K. (28). The cases occurred between November 2016 and the first half of 2017.⁴

Carfentanil also has potential in biological warfare. In October 2002, Russian security forces subdued Chechen hostage takers at the Moscow Dubrovka theater with an unidentified, incapacitating chemical aerosol, which led to the deaths of 125 people. Carfentanil and remifentanil (another fentanyl derivative) were reported found in the clothing and urine of people in the theater.⁵

According to multiple sources, China banned production and supply of 116 psychoactive substances, including fentanyl, in 2015; a ban on carfentanil followed in 2017. While a ban can cut production temporarily, it doesn’t stop it for long. Production places and supply routes change. Production for the U.S. market has moved to Mexico. Although a ban cuts off production, the drugs themselves will still be found in the supply chain for some time. Production may go further underground or move to different locations and supply routes may change.

**Fentanyl**

Fentanyl is a prescription medication developed for medical patients experiencing severe pain due to cancer and extremely invasive surgeries. Although the original intent was administration by health practitioners,
it evolved into an over-the-counter prescription available at any pharmacy or drugstore in the form of lozenges or a time-release gel patch. Street fentanyl can be exceptionally dangerous in relation to dosage (professional vs. amateur). As little as two milligrams of the white powder can cause a lethal reaction.

Fentanyl is a Schedule II narcotic under the United States Controlled Substances Act and approved by the Food and Drug Administration for limited use in pain relief. Fentanyl can be added to heroin or taken straight (injected, snorted/sniffed, smoked, taken orally by pill or tablet, or spiked onto blotter paper).

**Carfentanil**

Carfentanil is produced in large quantities in China and has been available as a high purity powder from websites that specialize in psychoactive products or so-called research chemicals and their marketing. Carfentanil is cut into heroin to increase its potency, and buyers generally don’t know what’s been mixed into the powder.

A 10-milligram dose of carfentanil is enough to sedate (immobilize) a wild female African elephant (weighing two or three tons); a captive female African elephant is administered a dose that is 25 percent less (7.5 milligrams). While this synthetic opioid was never designed for people or tested for use as a treatment, it’s easy to understand why a 0.02-milligram dose of carfentanil can kill a person weighing 200 pounds, which is a twentieth to a thirtieth the weight of a two- or three-ton wild or captive female African elephant.

Within minutes, carfentanil immobilizes an elephant (elephant is down). Within seconds, carfentanil can stop a person’s breathing and stop the person’s heart.

In December 2017, the World Health Organization (WHO) endorsed a recommendation from the Expert Committee on Drug Dependence (ECDD) to include carfentanil into Schedules I and IV of the 1961 U.N. Single Convention on Narcotic Drugs. Schedule I substances are subject to strict drug control measures. Schedule IV imposes the strongest possible regulations on substances by prohibiting production and supply of substances except under license for specific purposes, such as medical treatment and research. In the case of carfentanil, there is no indication for human use.

The 1961 convention has since been amended three times and carfentanil retains Schedules I and IV status.

**Naloxone**

Respiratory depression and subsequent respiratory arrest are the most serious adverse effects of any opioid overdose. The typical clinical picture in acute intoxication is the same as in opioid overdoses in general (i.e., a reduced state of consciousness, respiratory depression, and small pupils). Among the milder adverse effects of opioids, including fentanyl derivatives, are disturbances of the digestive tract, such as constipation and nausea. However, even at dosages of less than one milligram, fentanyl and its derivatives are substances with a powerful depressive effect on the central nervous system. The onset of these symptoms usually occurs within minutes of exposure.

Naloxone is used for the full or partial reversal of central nervous system and respiratory depression caused by opioids. The U.S. Food and Drug Administration approved a handheld naloxone intramuscular or subcutaneous auto-injector in 2014 and an intranasal formulation in 2015.

Administering naloxone can reverse an overdose of fentanyl, carfentanil, and other opioids, although when administering an antidote, the strength of the opioid needs to be taken into account. Multiple doses of naloxone may be required.

**Sources**


5. See note 4.


7. See note 4.


9. See note 3.

YOU MUST BE MEDICAL CERTIFIED TO TAKE THIS QUIZ

Answers to this quiz are found in the article “When You Need It Most,” which starts on page 36. Take this quiz for 1.0 CDE unit.

1. MPDS version 13.1 contains revisions to Protocol 23 and now includes:
   a. arsenic.
   b. hemlock and belladonna.
   c. fentanyl—and its chemical analog carfentanil.
   d. synthetic nerve agent VX.

2. Revisions in MPDS v13.1 to Protocol 23 exist in both ProQA and the printed cardsets.
   a. true
   b. false

3. The emergency dispatcher should be prepared to omit or discontinue all DLS instructions involving touching the patient if the:
   a. caller spontaneously provides information that suggests the presence of carfentanil (powder or liquid) on or in the immediate area of the patient.
   b. caller questions the safety of touching the patient when a known (or suspected) synthetic opioid is present.
   c. both a and b

4. If the complaint description involves hazardous materials (toxic substances) that pose a threat to bystanders or responders, go to:
   d. Protocol NABC-1.

5. Fentanyl overdose is confined strictly to the U.S.
   a. true
   b. false

6. Fentanyl can be deadly after ingesting as little as:
   a. two milligrams.
   b. four milligrams.
   c. eight milligrams.
   d. one gram.

7. Carfentanil was developed:
   a. for medical patients experiencing severe pain due to cancer and extremely invasive surgeries.
   b. for use in memory loss research.
   c. to immobilize human surgical patients undergoing prolonged procedures (such as heart transplants).
   d. to be a large animal tranquilizer.

8. The 1961 U.N. Single Convention on Narcotic Drugs lists carfentanil as a:
   a. Schedule I and II drug.
   b. Schedule I and IV drug.
   c. Schedule II and III drug.
   d. Schedule III and IV drug.

9. The most serious adverse effect(s) of any opioid overdose is/are:
   a. disturbances of the digestive tract.
   b. difficulty speaking between breaths.
   c. combative and aggressive behaviors.
   d. respiratory depression and subsequent respiratory arrest.

10. Naloxone is used for the full or partial reversal of:
    a. central nervous system and respiratory depression caused by opioids.
    b. swelling and irritation of the choroid of the eye caused by opioids.
    c. stroke among those with atrial fibrillation following opioid overdose.
    d. immune system deficiency caused by opioids.

To be considered for CDE credit, this answer sheet must be received no later than 10/31/19. A passing score is worth 1.0 CDE unit toward fulfillment of the Academy’s CDE requirements. Please mark your responses on the answer sheet located at right and mail it in with your processing fee to receive credit. Please retain your CDE letter for future reference.
Los Angeles, California (USA), has had a rocky history regarding emergency medical dispatch since the 1980s. A seminal case of Ziporah Lam that occurred Dec. 26, 1987, exposed serious problems in the city’s dispatch center there called Operations Control Division (OCD). The case made the front page of the LA Times and finally the CBS show, “60 Minutes,” which aired on Christmas Day nearly a year to the day the next year. As a result, but before this aired, Mayor Tom Bradley ordered a complete revamp of the center, which had basically an unstructured orientation course for calltakers, all of which were California State certified EMT firefighters with significant street experience before their assignment to OCD. The fledgling Medical Priority Consultants’ team and I were summoned by the mayor’s office to “fix the dispatch system.” Formal training and use of a structured protocol with scripted Pre-Arrival Instructions, including QA case review and feedback, were put into place, over the next several years.

Before this occurred, the paramedic union, United Paramedics of Los Angeles, led by paramedic supervisor Fred Hurtado, had been pushing the fire administration for years to fix things and specifically end the process of “no sending” if a call didn’t meet some unwritten definition of a non-emergency. They had placed significant pressure on city hall to do something. The Lam case achieved this goal (the hard way) as it was unfortunately classified both on the first and second call as a “no send.” The third call heralded her pre-arrest seizure, after which she died of an acute myocardial infarction (AMI). At our urging early on in the implementation process, we stressed that defining things in diagnosis-like terms was fraught with danger and indeed was the root cause of the Lam misfortune. This eventually struck a chord with the medical director and the Deputy Chief of Operations, Timothy De Luca (of De Luca’s Law fame), who issued this Departmental Bulletin No. 88-46. This issue’s Blast, while From the Past, is still very relevant today.
October 4, 1988

TO: All Fire/EMS Officers

FROM: Timothy R. De Luca, Deputy Chief, Operations

SUBJECT: THE HYPERVENTILATION SYNDROME

All cases of hyperventilation should be viewed as problems with respiration and treated as such. Dispatchers should categorize this as "difficult breathing" and dispatch an appropriate level of response. Paramedic units should also treat cases of "hyperventilation syndrome" as a case of shortness of breath and make base station contact as delineated under the Department of Health Services Reference Number 808. (Note: Current base station contact criteria are being clarified to reflect this interpretation.) EMT-I rescue ambulances should transport all such patients to the closest appropriate facility. Fire companies should not cancel ALS responders who have yet to arrive on scene.

The "hyperventilation syndrome" occurs when people breathe faster or deeper than normal, resulting in an increase in the pH of the blood. The symptoms that can result include numbness and tingling in the hands and about the mouth, a sensation of air hunger, light-headedness, near syncope (fainting), and chest pain. Fortunately, the most common cause of this syndrome in young people is simple anxiety.

However, although it occurs with much less frequency, these same symptoms can be present in young people with life threatening medical problems. Pulmonary embolus can occur in young people and lead to hyperventilation due to a lowered blood oxygen content. Myocardial infarction (heart attack) could be misdiagnosed as "hyperventilation syndrome" due to the presence of chest pain, "numbness" in the arms and shortness of breath. Other serious medical problems presenting with hyperventilation and anxiety include the early phases of aspirin overdoses and the early stages of sepsis.
In the pre-hospital setting, it is hardly ever possible to exclude these less frequent but serious medical problems from the innocent form of the "hyperventilation syndrome." Even temporary reversal of symptoms by calming or using a paper bag are not 100% reliable, as we have seen in two recent cases. The fact that normal pulse rate and blood pressure exists cannot be used to exclude the uncommon event of a myocardial infarction in a younger individual presenting with hyperventilation and "numbness" in the hands.

Again, all cases of hyperventilation should be viewed as problems of a potentially serious medical cause and treated as such.

TIMOTHY R. DU LUCA, Deputy Chief Commander of Operations

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STOP THE PRESSES
EMD is the news behind baby’s delivery

Audrey Fraizer

Wayne County 911, New York (USA), might get a lot of calls for “baby on the way,” but it’s the few and far between emergency dispatcher that makes the delivery.

“The calls aren’t rare, but delivery before an ambulance certainly is,” said Greg DeWolf, Wayne County 911 Operations Manager. Supervisor Matthew Bixby, EMD, was one of the lucky ones.

Bixby was taking calls during first shift on Monday, March 26, when a father-to-be rang 911 for an ambulance. His fiancée was in labor, and he had rushed home while on his way to work, summoned by her phone call to turn around. That’s exactly what he did and barely in the nick of time.

Although contractions were five minutes apart when Bixby connected at 8:53 a.m., it was before the clock struck nine that Bixby was giving dad Medical Priority Dispatch System™ (MPDS®) childbirth and delivery instructions. Mom was in the bathroom, and Bixby “highly encouraged” her to move from her position on the toilet. While dad lowered her into the bathtub, he also sent his stepson on a task to retrieve the string for tying off the umbilical cord and the towels to keep his new sibling warm until the ambulance arrived.

“Dad was great,” Bixby said. “He did everything. He listened, followed instructions, and caught the baby.”

Baby Bruce clocked in at 9:01 a.m. Four minutes later, the ambulance arrived for transport to the hospital. Mom and Bruce were home two days later.

Dad was also “extremely calm” during the call and so, apparently, was mom. After delivering the six-pound, six-ounce boy, she leaned toward the direction of the phone—the speaker was on—to reassure Bixby about their situation.

“She was out of breath,” said Bixby, who had the rare opportunity of hearing over the phone a newborn let out his first cry. “But she was calm enough to say they were doing well.”

DeWolf was in his office and after hearing the news—and after reviewing the call—he wasted no time in sending out a press release. After all, DeWolf wasn’t about to let his emergency dispatcher get lost in the shuffle for such a positive event (considering what happened the year before when accolades following a similar incident failed to mention emergency dispatch).

“These guys do a tremendous job,” DeWolf said. “I want to make sure they get the recognition deserved.”

The acknowledgement, however, will go beyond air time and type (13WHAM-TV and the Finger Lake Times newspaper). Bixby now has a stork pin to wear on his uniform, and his actions will be put into proclamation by Wayne County Government. His name will be among the first engraved on a perpetual plaque that from baby Bruce’s day forward commemorates emergency dispatchers who experience the great fortune of helping to complete a baby delivery over the phone. And the really cool part? Dad contacted him to say “thank you.”

Bixby used to work in customer service for the phone company. He switched to 911 three years ago and finds helping people in emergency situations a more satisfying fit. “I like what I’m doing,” he said. “At the end of the day, I know I’ve helped someone. Always. It’s a lot better than helping people lower their phone bills.”

DeWolf couldn’t be any prouder than a new dad about his emergency dispatchers. “The efforts of Supervisor Bixby are a fine example of the excellent service provided every day by all of the team members in the 911 center in Wayne County,” DeWolf said.

According to records, Wayne County 911 emergency dispatchers aided in the full delivery of a baby six times since 2015 (including the most recent call).
AWARD-WINNING SAVE
Successful CPR on baby brings recognition to Tennessee center

Josh McFadden

Does it ever feel as though emergency dispatching is a thankless job? You take call after call on what is probably the worst day of a person's life. People get frustrated with you; they may even shout and curse at you as you ask pertinent questions and give instructions. When the call is over, you usually don't hear anything about the caller or patient again. Your efforts may largely go unnoticed.

It's always gratifying when someone acknowledges your good work. The team at Grainger County E-9-1-1, a small agency in Rutledge, Tennessee (USA), recently got a taste of how it feels. In May, the center won the Children's Emergency Care Alliance's Star of Life Award for a call emergency dispatcher Tennie “Tee” Roberts took at the end of November 2017.

The call came in from Heather Watson, who reported her four-week-old son, Dallas, was not breathing. The mother had put the infant in his swing and briefly left the room. When she returned, Dallas was not only not breathing, but he was unconscious and had blood coming from his mouth and nose. After Roberts began questioning Watson, the frantic mother said Dallas was turning blue.

Roberts' co-worker emergency dispatcher Allie Mathis dispatched Grainger County EMS to the caller's location. Meanwhile, Roberts instructed Watson to give her young son rescue breaths and CPR. She provided reassurance and helped instill confidence in the mother. After a short time, Roberts was relieved to hear the baby cry, and she told Watson this was a good sign.

By the time paramedics arrived, Dallas was breathing on his own. The call came in from Heather Watson, who reported her four-week-old son, Dallas, was not breathing. The mother had put the infant in his swing and briefly left the room. When she returned, Dallas was not only not breathing, but he was unconscious and had blood coming from his mouth and nose. After Roberts began questioning Watson, the frantic mother said Dallas was turning blue.

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By the time paramedics arrived, Dallas was breathing on his own. They took him to a hospital in Knoxville, the nearest major city in Tennessee. From there, he was sent to Vanderbilt University in Nashville, Tennessee.

“Clearing the airway and giving rescue breaths saved his life,” said Randy Holt, Director of the Grainger County Emergency Communications District E-9-1-1. “Doctors told us without intervention from the 911 dispatchers, this was a dead baby.”

In May, Roberts and Mathis accepted the Star of Life Award at a banquet in Nashville. The Children's Emergency Care Alliance presented six of these awards (one for each of the six regions in Tennessee); Grainger County won for Region 6 and was among many candidates. “We're as proud as anyone could be,” Holt said. “Just to be nominated is a great honor.”

Grainger County Emergency Medical Center is a two-seat agency that serves a population of only 23,000 residents. Holt said it was significant to beat out much larger agencies. “With the competition we were up against—when you’re as good as they are, it’s a big deal,” he said.

Grainger County Emergency Medical Center went live with the Medical Priority Dispatch System™ (MPDS®) and ProQA® in 2004. Holt said his center has been ahead of most others in the region when it comes to handling emergency calls.

“Hardly anybody was [using the Protocol in Tennessee] in 2004,” he said. “We've led the way in Emergency Medical Dispatch.”

What makes Roberts’ performance with the award-winning call even more amazing is that she had just completed EMD training the week before. Plus, she got the surprise of her life on April 12 when Watson brought Dallas into the center for a visit. The baby was perfectly healthy, and Roberts and the grateful mother had an emotional reunion.

Holt captured the moment on his cellphone camera, which he then posted on the agency’s Facebook page. Subsequently, local news media picked up on the story and ran a piece on television. ABC national news even posted the video on its website and Facebook page.
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PLANNING AHEAD
Do you have an emergency plan in your center?

Becca Barrus

It's a well-known fact that emergency communication centers get flooded with calls during the aftermath of a natural or manmade disaster. After Hurricane Harvey hit land surrounding the Gulf of Mexico in 2017, 911 centers and emergency responders were so bogged down with calls that people took to Twitter to send out distress calls in hopes of being rescued. What might not be so well-known is that, although they may be better prepared to deal with disasters, communication centers aren't immune to them.

September is National Preparedness Month in the United States, and it's as good a time as any to remind managers and line dispatchers alike to have a refresher course on their emergency action plans.

Here in Salt Lake City, Utah (USA), we live right along the edge of a 240-mile long fault line that is predicted to cause an earthquake of at least a 7.5 magnitude the next time it rumbles. It isn't just the earthquake that's the problem, it's the fallout: downed power lines, possible fires, weakened building structures, damage to water lines, etc.

Because of the fault line's looming threat, Utah is a big proponent of emergency preparedness. Beth Todd, Fire Operations Manager at Salt Lake's Valley Emergency Communications Center (VECC), has worked with Salt Lake County Emergency Management, along with other cities' emergency managers, to develop an action plan for the county at large and, more specifically, within her center.

The basic plan was developed and completed before Salt Lake City hosted the 2002 Winter Olympics just four months after 9/11. Security was tight, and officials had to know they would be ready to handle anything that could happen.

The emergency plan that Todd helped create for her center adopted an all-hazards approach, but there are individual annexes designed for responses to specific kinds of incidents. For example, it asks what the center would do during a flu pandemic if 50 percent or more of their staff was impacted. How would they be able to continue to operate?

In addition to having emergency policies and procedures, VECC has made physical preparations as well. Todd ensured that supplies were purchased for employees, like 72-hour kits, food, and water, and there is a designated place for emergency dispatchers to sleep in case they can't leave the building, complete with air mattresses and blankets.

So far VECC hasn't had to use their emergency protocols for an earthquake or fire. The only time the center was fully evacuated was during a mishap possibly involving an accidental mixing of cleaning chemicals. Hazmat was called to investigate and ventilate the building while the staff stayed outside for about 45 minutes. During that time, they didn't sit around and wait for things to get back to normal. They still had emergencies to address. In order to maintain operations, the emergency dispatchers used handheld radios and their evacuation kits, which included paper versions of digital forms they would normally fill out at their computers, that allowed them to carry on as close to normal as possible.

If your center needs to create or spruce up an emergency plan, Todd recommends that you work with emergency management personnel on a city or county level. It will save a lot of time to get on the same page and understand each other's expectations from the beginning. It's important that the 911 center's emergency plan can integrate well with the emergency plans of the county and other emergency responders.

Once you have a plan, make sure employees are trained. Todd emphasized that special considerations should be taken in the PSAP due to turnover. Your more seasoned emergency dispatchers might know the drill, but what about the new hires?

An emergency plan is just another form of protocol. You may not end up having to use it in extreme circumstances, but in the event that you do, everyone involved will be much more comfortable and calm knowing that there's structure there to catch you.
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